

**THE CURRENT STATUS OF AND QUALITY
IN THE MEDICARE ADVANTAGE PROGRAM**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS
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**THE CURRENT STATUS OF AND QUALITY
IN THE MEDICARE ADVANTAGE PROGRAM**

TUESDAY, MAY 8, 2018

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:01 a.m. in Room 1100 Longworth House Office Building, the Honorable Peter Roskam [Chairman of the Subcommittee] presiding.
[The advisory announcing the hearing follows:]



WAYS AND MEANS

CHAIRMAN KEVIN BRADY

Chairman Roskam Announces Hearing on the Medicare Advantage Program

Committee on Ways and Means Subcommittee on Health Chairman Peter Roskam (R-IL) announced today that the Subcommittee will hold a hearing on “The Current Status of and Quality in the Medicare Advantage Program.” The hearing will focus on opportunities to improve and grow the Medicare Advantage program. The witnesses will speak to the operation of high quality plans and challenges faced by new emerging insurers, consumer interactions with Medicare Plan Finder, and quality measurement in the program. **The hearing will take place on Tuesday, May 8, 2018 in 1100 Longworth House Office Building, beginning at 10:00 AM.**

In view of the limited time to hear witnesses, oral testimony at this hearing will be from the invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “Hearings.” Select the hearing for which you would like to make a submission, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, May 22, 2018**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve

the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at <http://www.waysandmeans.house.gov/>

Chairman ROSKAM. The Subcommittee will come to order. Welcome to the Ways and Means Health Subcommittee hearing on the current status of and quality in the Medicare Advantage program.

I am honored to welcome our four witnesses today as we continue our discussion on improvements to the Medicare program and turn our focus to Medicare Advantage, where nearly 40 percent of seniors with Parts A and B coverage are choosing to enroll.

The Medicare Trustees continue to project more seniors will choose Medicare Advantage plans in the coming years. These statistics highlight the popularity of the Medicare Advantage program, demonstrating that seniors prefer the choice the program continues to provide. And by expanding competition in the Medicare program, Medicare Advantage has proven that choice and competition work in keeping health care costs low for seniors and to improve care.

Today, we will hear from our panel of witnesses of what Medicare Advantage plans are doing well and how the government can get out of the way to spur more plan competition and better health care outcomes in our Medicare population.

The hearing will also give us an opportunity to examine the existing quality measurement system in the Medicare Advantage program.

And finally, we will learn about consumer interactions with Medicare Plan Finder and how this beneficiary tool may be improved to keep up with our technology-savvy seniors.

As the Medicare Advantage program continues to grow in size, we must ensure that it is able to grow with technological advances and the evolving health care delivery techniques that we have come to expect.

The Medicare Advantage program has come a long way, and can be used as a testing ground for many health care innovations that are unavailable in traditional Medicare. How we incentivize innovation that leads to better health quality—access and outcomes are vital.

While the Star Ratings system has the ability to help drive these changes, effective measurement is the first step. And I appreciate the solution-based testimonies of the witnesses here today, and the Subcommittee looks forward to fleshing out the details of their proposals throughout this hearing.

Now I am pleased to recognize my friend and colleague, the distinguished Member from Michigan, the Ranking Member, Mr. Levin, for the purposes of an opening statement.

Mr. LEVIN. Thank you, Mr. Chairman, and for this hearing. And thank you to our witnesses for joining us this morning.

The Medicare Advantage program is based in the promise for choice for seniors, and beneficiaries today enjoy more choices than ever before.

Those who prefer care without restrictions on doctors and hospitals can enroll in the traditional Medicare program. Those who prefer a managed care alternative have the option to enroll in Medicare Advantage. Reforms made by the Affordable Care Act have improved quality and reduced overpayments in Medicare Advantage, while still providing 99 percent of seniors access to a plan.

For the promise of choice to be a meaningful one, Medicare beneficiaries must be given complete and accurate information. A 2017 Kaiser Family Foundation study found that 35 percent of Medicare Advantage enrollees are in plans with narrow provider networks.

Additionally, in many states, beneficiaries with pre-existing conditions who wish to switch back to traditional Medicare can be subjected to discrimination in underwriting in the private Medigap market.

These and other trade-offs are not adequately conveyed to beneficiaries on the current Medicare Plan Finder Web site.

It is also crucial that we acknowledge and respect the choice of the two-thirds of beneficiaries who are enrolled in traditional Medicare by addressing counter-productive limitations in the program.

For example, Committee Democrats have introduced legislation to provide all seniors with comprehensive dental, vision, and hearing coverage. Denying coverage for these essential services not only hurts beneficiaries, but can also lead to greater expenses when untreated conditions lead to complications.

I would further draw the Chairman's attention to an area of bipartisan agreement regarding Medicare choices. At a September 2017 markup, Chairman Brady affirmed his commitment to ensuring parity in telehealth benefits between traditional Medicare and Medicare Advantage. We are still waiting to see action on that

commitment. Recent expansions of supplemental benefits in Medicare Advantage further underscore the need to provide parity to all seniors.

We would also be remiss if we failed to discuss recent regulatory actions by the Trump Administration that could undermine choice and increase confusion for Medicare beneficiaries under the guise of promoting flexibility. Weakening of plan-designed rules in the 2019 Call Letter could allow plans to cherry-pick and discriminate against sicker beneficiaries.

CMS has also signaled an intent to roll back consumer protections in the Medicare Marketing Guidelines without providing a draft for public comment.

Finally, as we discuss choices for Medicare beneficiaries, let us remember the very difficult choices so many have in finding a way to pay for their prescription medicines. President Trump has been promising to lower these costs—a pledge we will likely hear again this week. But there has been a painful lack of action on this issue.

Democrats have put forward and stand ready to act on real reforms, including allowing Medicare to directly negotiate prices in Part D with drug manufacturers.

Mr. Chairman, I urge you to call a hearing in the near future on addressing the high cost of prescription drugs.

Once again, I would like to thank the witnesses for joining us this morning, and we all look forward to a constructive conversation.

Thank you, Mr. Chairman.

Chairman ROSKAM. Thank you, Mr. Levin. Now let's turn to our witnesses.

Firstly, we will hear from Karoline Mortensen, Associate Professor at the University of Miami. She will discuss research surrounding quality measurement and how data can be refined to improve information used by policymakers, plans, and consumers.

Then we will hear from Andrew Toy, Chief Technology Officer at Clover Health, an emerging health care start-up focused exclusively on Medicare Advantage. And he will discuss the data-driven model developed by Clover Health to best serve Medicare beneficiaries and the challenges faced by new entrants in the Medicare Advantage program.

Now, I would like to yield to my friend from Butler, Pennsylvania to introduce our third witness.

Mr. Kelly.

Mr. KELLY. Thank you, Chairman. It is my pleasure to introduce Ms. Daphne Klausner. And we just talked briefly. She is from Philadelphia, and I was congratulating her on her Superbowl win, and I told her how sorry we were in Pittsburgh that we let the Stanley Cup get away from Pennsylvania this year.

But Ms. Klausner is the Senior Vice President of Senior Markets at the Independence Blue Cross. She provides overall leadership to Independence Medicare business, encompassing operations, sales and marketing, risk analysis, and performance management areas, which also includes oversight of the Medicare Star Rating initiatives.

Independence Blue Cross is one of the largest health insurers in Pennsylvania and serves over 8.5 million people in 24 states. Medicare Advantage, they cover over 100,000 beneficiaries.

Also, Ms. Klausner, as you know, in the district that I represent, over half of the people take advantage of Medicare. So we have to make sure that we are doing the right things for the right reasons.

So thank you so much for being here today and taking time out of your busy schedule to be with us. We appreciate it.

Chairman ROSKAM. And then we will hear from Jack Hoadley, a researcher from the Health Policy Institute at Georgetown University. He is here to discuss the findings of a recent report from the National Council on Aging and the Clear Choices Campaign on Modernizing Medicare Pathfinder to Improve Consumers' Medicare Shopping Experience.

So, Ms. Mortensen, you are recognized for five minutes.

STATEMENT OF KAROLINE MORTENSEN, PH.D., ASSOCIATE PROFESSOR, HEALTH SECTOR MANAGEMENT AND POLICY, UNIVERSITY OF MIAMI BUSINESS SCHOOL

Ms. MORTENSEN. Thank you. Chairman Roskam, Ranking Member Levin, and distinguished Members of the Subcommittee on Health, thank you for the opportunity to appear today to discuss quality ratings in Medicare Advantage plans.

I am an Associate Professor of Health Sector Management and Policy at the University of Miami in Florida, where I teach and conduct research on the delivery, financing, and organization of the health care system.

Some of my research does look at outcome measures in managed care programs that are publicly funded or federally funded.

I earned my Ph.D. in Health Services Organization and Policy at the University of Michigan. The first thing you learn as a student at the University of Michigan studying health care is the Donabedian framework for measuring quality of health care. The Donabedian framework assesses structure of health care processes in health care, as well as outcomes in health care. And you see other matrices as well, like patient experience and access measures.

Most of the measures you see, particularly in the Medicare Star Quality Rating Rankings, are process measures, and there are a number of reasons why process measures are included. They are the easiest metrics to measure in that they tend to be in adherence to clinical guidelines. And, perhaps most importantly, they are the metrics that physicians have the most direct control over delivering those processes. So processes could include whether or not a physician conducted an eye exam or a foot exam on a diabetic patient.

Now what those process measures don't capture, though, is what happens to that patient once they go home. Do they develop blindness related to that diabetes or not? So those would be outcome measures, which measures of this Subcommittee are concerned about and would like to see more outcomes measures in Medicare Advantage plans, as would a lot of the plans would like to see these measures, as well.

So what do outcome measures mean? They mean once you have done these processes and encouraged a good structure of a health

care system, how do you ensure that the individual's health or the population's health is actually improving? So we are pushing today to talk more about incorporating more of these outcomes measures.

Outcomes measures provide insight into the quality of care provided. The one downside is that they can be influenced by factors that happen outside of the health care system, like patient compliance or issues with social determinants of health.

When you look at quality, as defined by the former Institute of Medicine, the word "outcomes" is actually in the definition of "quality," where, "quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

So, specifically looking at the Medicare Star Ratings, those are designed to reflect quality of care delivered, both for the beneficiary, so they can make an informed plan choice and look for a four or a five-star plan, but they are also used post-Affordable Care Act for reimbursements at a higher level, incentive payments for these plans. So plans are paying a lot of attention to these metrics and could be incentivized to focus more so, particularly if they are outcomes-oriented metrics.

Medicare reimburses these plans, the private plans, on a risk-adjusted per-capita payment, as opposed to traditional fee-for-service Medicare. So we focus on these quality rankings, and the rankings include outcomes, intermediate outcomes, patient experience, access, and process. But of the about 45 metrics, only 3 of these metrics are actually outcome-based.

So what are those metrics? Those metrics include all cause readmission rates, which are important for Medicare, in general, to focus on. But they also include maintenance and improvement and self-reported physical health and self-reported mental health. So there are a lot of potential opportunities to include other outcomes measures into these metrics.

Now, I want to be careful. One of the issues we struggle with in health care is what we call now "measurement cacophony," where we have so many measures—I am not encouraging that we add on additional measures; I am suggesting perhaps we focus on how many process measures we have, whether some of those could be removed. The Medicare Advantage plans already have more measures than any of the other value-based plans in Medicare. So perhaps you could remove some of these process metrics and focus on measures that are more outcome-based, and perhaps more clinically meaningful.

And also perhaps relate back to the health services area, geographic area where the beneficiary resides. So a lot of these metrics are happening at a contract level, which can span across, as you mentioned before, four different states. So it would be important for the beneficiaries to see what are some of the metrics happening in their zip code or in their geographic area.

So I appreciate that there is attention and focus on this matter, and I thank you for your time.

Chairman ROSKAM. Thank you.

[The prepared statement of Ms. Mortensen follows:]

Written Testimony of
Karoline Mortensen, Ph.D.
Associate Professor
Department of Health Sector Management and Policy
University of Miami Business School

For a Hearing

Before the
United States House of Representatives
Committee on Ways and Means, Subcommittee on Health

On
Medicare Advantage Update
May 8, 2018

Introduction

Chairman Roskam, Ranking Member Levin, and distinguished Members of the Subcommittee on Health, thank you for the opportunity to appear today to discuss the status of quality measures in Medicare Advantage plans.

As a professor of health sector management and policy, I teach and conduct research on the financing, organization, and delivery of the U.S. health care system, including the policies and programs that shape and define our fragmented system. I earned my Ph.D. in Health Services Organization and Policy from the University of Michigan in 2006. I have published two book chapters on Health and Health Care in Retirement (Medicare).^{1,2} I have also published articles in the peer-reviewed academic literature on managed care in publicly financed health insurance programs, including outcomes assessment in managed care. I live and work in Miami-Dade County, Florida, where 65% of Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans, one of the highest penetrations in the country.³

Quality Measurement

Quality measurement in health care spans measurement of structure, process, and outcomes,⁴ as well as patient experience and access.⁵ Ensuring quality of the structure of health care (hospitals, health systems, etc.) is largely overseen by accrediting organizations such as the Joint Commission. Structural measures assess, for example, whether the organization uses electronic health records, the ratio of providers to patients, or the proportion of board certified physicians.⁶ Measures of process in health care abound, for a number of reasons. Process metrics are relatively easy to measure, they are consistent with national guidelines, and they represent the activities clinicians control the most directly (McGlynn).⁷ Process measures track whether and how many times a service was provided for a targeted population, e.g. whether an eye exam was performed on a diabetic patient.

The majority of health care quality measures used for public reporting are process measures.⁸ They can be informative to consumers about the care they can expect to receive. A limitation to process measures is that they may assess whether the provider prescribed a medication therapy, but not whether the patient filled the prescription, correctly took their medication, or if their outcomes improved due to the therapy. Although process measures play an important role in

¹Mortensen K, Villani J. Healthcare and Health Insurance in Retirement. In Wang M, editor: Oxford Handbook of Retirement. Oxford University Press. 2012.

²Mortensen K, Bloodworth R, Gaeta R. Health Insurance and Healthcare in Retirement. In Krauss Whitbourne, S., editor: The Encyclopedia of Adulthood and Aging. Wiley-Blackwell. December, 2015.

³Jacobson G, Damico A, Neuman T, Gold M. Medicare Advantage 2017 Spotlight: Enrollment Market Update. 2017. Kaiser Family Foundation.

⁴Donabedian A. Evaluating the Quality of Medical Care. *Milbank Quarterly*. 1966;44:Suppl:166-206.

⁵Centers for Medicare & Medicaid Services. Fact Sheet- 2017 Star Ratings.

⁶Agency for Healthcare Research and Quality. Types of Quality Measures.

⁷McGlynn E, et al. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine*. 2003;348:2635-45.

⁸Agency for Healthcare Research and Quality. Types of Quality Measures.

quality measurement, members of this Committee, clinicians, administrators, and other stakeholders have concerns that the focus on process in the MA quality Star Ratings should be complemented with more of a focus on outcomes. This is the topic of my testimony today.

Outcome measures reflect the results of a process, and the impact of the health care service or intervention on the health status of patients.⁹ Outcome measures provide insights into the quality of care provided, but can also be influenced by factors outside of the health care system, like patient compliance, socioeconomic, or social determinants of health.

Outcomes are in the definition of quality, as defined by the National Academies of Sciences, Engineering, and Medicine. “Quality is the degree to which health services for individuals and populations increase the likelihood of desired health *outcomes* and are consistent with current professional knowledge.”¹⁰ Outcomes are the quality and cost targets that health care providers seek to improve. Outcomes are the “gold standard” in quality measurement. Outcomes include mortality, readmission rates, surgical site infection rates, patient experience, ambulatory care sensitive (preventable) utilization, etc.¹¹ Some outcomes are more relevant for hospitals, while others are more relevant for health plans, while some pertain to both. Outcomes assessment is critical for assessing success in the pursuit of the Triple Aim: improve the patient experience of care, improve the health of populations, and reduce the per capita cost of health care.¹²

Measurement, and specifically outcomes assessment, in health care is important. It is increasingly so as the financing of health care in our system transitions from volume-based reimbursement to value-based reimbursement. Medicare is expected to see this transition occur more rapidly than most payers.¹³

Many providers and administrators feel there is an overabundance of measures. The National Quality Metrics Clearinghouse sponsored by the Agency for Healthcare Research and Quality (AHRQ) lists a total of almost 2,000 measures across five clinical categories (structure, process, outcome, access, and patient experience), with 244 clinical quality measures related to outcomes.¹⁴ The proliferation of quality measures and quality reporting requirements have resulted in “measurement cacophony.” Parsimonious and judicious use of measures should be encouraged. Some stakeholders argue the burden of a greater number of measures for MA plans is higher than any other value-based program, so they recommend reducing the number of measures, making them clinically meaningful outcome measures, and adjusting for

⁹ Agency for Healthcare Research and Quality. Types of Quality Measures.

¹⁰ National Academies of Sciences, Engineering, and Medicine. Crossing the Quality Chasm: The IOM Health Care Quality Initiative.

¹¹ Tinker A. The Top 7 Outcome Measures and 3 Measurement Essentials. HealthCatalyst.

¹² Berwick D, Nolan T, Whittington J. The Triple Aim: Care, Cost, and Quality. *Health Affairs*. 2008;27(3):759-69.

¹³ Burwell S. Setting Value-Based Payment Goals- HHS Efforts to Improve U.S. Health Care. *New England Journal of Medicine*. 2015;372(10):897-8.

¹⁴ This valuable clearinghouse at qualitymeasures.ahrq.gov will sunset on July 16, 2018 due to a lack of federal funding, a true blow to quality measurement in the United States.

socioeconomic status of beneficiaries.¹⁵ This would substantially reduce the burden on providers without sacrificing quality.

Medicare Advantage Star Ratings

The MA program in 2017 included 185 organizations offering approximately 3,300 plan options, enrolling 19 million Medicare beneficiaries (33%), an enrollment increase of 71% since the passage of the ACA in 2010.¹⁶ Medicare reimburses these private plans on a risk-adjusted, pre-determined per person rate rather than a fee-for-service (FFS) reimbursement.

The Centers for Medicare & Medicaid Services (CMS) implemented Star Ratings reflecting quality of care in MA contracts over 10 years ago, with a 3 star system. The intent of the ratings system was to provide accurate comparative information to Medicare beneficiaries about the quality of care they can expect to receive from the private health plans. The intent of the Star Rating system is to capture information on patient experience, clinical quality, and administrative quality of the plans. The Star Ratings span five broad categories: Outcomes, Intermediate Outcomes, Patient Experience, Access, and Process.¹⁷

MA plans that include Part D prescription drug coverage (MA-PD) are evaluated at the contract level (not the plan level) on up to 44 unique quality and performance measures. Half of the contracts in 2017 received 4 or more stars, and two-thirds (68%) of MA enrollees are in contracts with ratings of 4 or more stars in 2017.¹⁸

Star Ratings reflect value beyond informing the consumer's decision-making process. Beginning in 2012, MA plans are eligible to receive bonus payments if they achieve an overall rating of 4 stars or higher on CMS's 5 star rating system. The incentives for private MA plans are significantly different than they were in the Plus Choice plans and in the period before the Affordable Care Act. Quality bonuses in 2018 will add 4% to the average plan's base benchmark, and will add 3% to plan payments. Risk adjustments for higher enrollee risk also result in higher payments to the plan.

Current Measures Used in Star Ratings

Several of the measures in the MA program are consistent with CMS' Core Quality Measures.¹⁹ CMS reports quality of MA plans with data derived from four sources:

- 1) The Healthcare Effectiveness Data and Information Set (HEDIS) is a data set of process and intermediate outcome measures from National Committee for Quality Assurance (NCQA).
- 2) The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

¹⁵ Anthem Public Policy Institute. Opportunities to Strengthen the Medicare Advantage Star Ratings Program. 2017.

¹⁶ MedPAC March 2018 Report to Congress: Medicare Payment Policy.

¹⁷ Centers for Medicare & Medicaid Services. Fact Sheet- 2017 Star Ratings.

¹⁸ Jacobson G, Damico A, Neuman T, Gold M. Medicare Advantage 2017 Spotlight: Enrollment Market Update. 2017. Kaiser Family Foundation.

¹⁹ Centers for Medicare & Medicaid Services. Core Measures.

- 3) The Health Outcomes Survey (HOS), a CMS survey of self-reported health outcomes
 4) CMS administrative data.

Data from Anthem Public Policy Institute, illustrated in the chart below, suggest that the number of process measures (16) significantly exceeds the number of outcome measures (3) and intermediate outcome measures (6).

MA Star Rating Measure Type	2017 Measure Count	Percent of Total Measures	Weighted Measure Value*	Weighted Measure Percent of Total Weight
Process	16	36%	16	20%
Access	7	16%	10.5	13%
Experience	10	23%	15	19%
Intermediate Outcome	6	14%	18	23%
Outcome	3	7%	9	11%
Improvement	2	5%	10	13%

*Note this does not reflect that new measures all receive a weight of 1 their first year no matter their type.

Chart from the Anthem Public Policy Institute, available at:

https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mzmmw/-edisp/pw_g330429.pdf

The process measures include screenings (mammography, colorectal cancer screening), flu vaccine receipt, measures of diabetes exams, etc. Intermediate outcomes reflect factors or a short-term result that contribute to an ultimate outcome. For example, diabetes patients with a controlled A1c (intermediate outcome measure C15 in the 2018 Star Ratings) is an intermediate outcome, as controlled blood glucose levels prevent diabetes complications. The three outcome measures include self-reported maintaining or improving physical health and mental health, and Plan all-cause readmissions. Intermediate outcomes include blood sugar controlled (diabetes), blood pressure controlled, etc. (The full list of 2018 Star Ratings in on the last page for reference.)

The MA Star Ratings have come under scrutiny for not including more outcomes measures, and there is a lack of confidence that the quality ratings reflect outcomes that matter.²⁰ Only 20% of the quality measures focus on outcomes or intermediate outcomes.²¹ Progress on outcomes measurement has been slow, as the efforts are overwhelmingly led by specialty societies, although what matters are outcomes that encompass the whole cycle of care. The “let a thousand flowers bloom” approach has each organization reinventing the wheel, tweaking existing measures, or inventing ones of their own.²² Health insurers are at the forefront of overhauling their quality improvement strategies to incorporate outcomes-based quality measures.²³ For

²⁰ Goozman, M. Does Medicare Advantage Measure Up? Modern Healthcare. 2017.

²¹ Anthem Public Policy Institute. Opportunities to Strengthen the Medicare Advantage Star Ratings Program. 2017.

²² Porter M, Larsson S, Lee T. Standardizing Patient Outcomes Measurement. *New England Journal of Medicine*. 2016;374:504-6.

²³ Castellucci, M. Health Insurers among Leaders in Using Outcome Measures. Modern Healthcare. 2018.

example, Blue Cross Blue Shield of Louisiana tracks potentially avoidable emergency department visits and medication adherence.

Lack of data availability has been a key barrier to more outcomes-based measures. Data quality issues arise largely due to poor data quality in a managed care setting, where insurers are reimbursed a capitated amount per person, lessening the need for strict documentation as the care provided is capitated. This is in stark opposition to a fee-for-service environment, where providers bill for each service rendered and thus have significant documentation.

Researchers have not had access to the claims data from MA plans.²⁴ This has prevented more claims-based outcomes measures, and has made comparisons between FFS and MA difficult. CMS Administrator Seema Verma announced in April 2018 that researchers will now be able to access MA claims data. This is a positive step forward for health services research and outcomes measurement.

Suggested Outcome Measures

A systematic approach to assess and incorporate more outcomes measures for the MA Star Ratings is essential. There are validated outcomes measures in use by a variety of stakeholders across the country and the world.

Experts recommend using outcome measures from the International Consortium for Health Outcomes Measurement (ICHOM). ICHOM has approved or is in the final stages of approval of more than 20 sets of measures covering 45% of disease burden in the United States.²⁵

CMS can look to private insurers for outcome measures. Humana, a dominant player in the MA market, already assesses “Healthy Days” in the communities they serve, using the U.S Centers for Disease Control and Prevention (CDC) population health management tool that measures health related quality of life.²⁶ Seniors living in “Bold Goal” communities made improvements in physical and mental health, reducing their number of unhealthy days in 2017. This measure would incorporate the impact of MA plans’ upcoming foray into offering food security and other health-related need factors for their enrollees.

Ambulatory Care Sensitive Conditions (ACSCs) or Preventable Visits, either in the inpatient²⁷ or emergency department²⁸ setting, are outcome measures that assess access to care in a community. ACSCs are conditions for which timely and effective outpatient care can help reduce

²⁴ Brennan N, Ornstein C, Frakt A. Time to Release Medicare Advantage Claims Data. *JAMA*. 2018;319(10):975-6.

²⁵ Porter M, Larsson S, Lee T. Standardizing Patient Outcomes Measurement. *New England Journal of Medicine*. 2016;374:504-6.

²⁶ Humana. Humana Releases its 2018 Bold Goal Progress Report.

²⁷ Hu T, Mortensen K. Mandatory Statewide Medicaid Managed Care in Florida and Hospitalizations for Ambulatory Care Sensitive Conditions. *Health Services Research*. 2018;53(1):293-311.

²⁸ Hu T, Mortensen K, Chen J. Medicaid Managed Care in Florida and Racial and Ethnic Disparities in Preventable Emergency Department Visits. *Medical Care*. 2018. In press.

the risks of hospitalization.²⁹ These are assessed readily with tools available by the Agency for Healthcare Research and Quality using their Prevention Quality Indicators (PQI) tool (qualityindicators.ahrq.gov). These are often measured using county population in the denominator, making this a meaningful measure relative to a beneficiary's geographic location. The release of MA claims data facilitates these types of outcome measures.

MedPAC members have expressed desire to see more Patient Reported Outcomes (PROs) or Patient Reported Outcome Measures (PROMs). CMS PROs are already incorporated into the new Merit-based Incentive Payment System (MIPS).

The Institute for Healthcare Improvement (IHI) has a variety of outcomes they recommend to measure population health and the Triple Aim.³⁰ These include Years of Potential Life Lost (YPLL), mortality amenable to health care, and Health Risk Assessment (HRA) scores. HRAs measure "How's your health?" A survey assesses "When you think about your health care, how much do you agree or disagree with this statement: I receive exactly what I want and need exactly when and how I want and need it?" A measure assessing likelihood to recommend the MA plan reflects patient experience of care. An experience of care outcome is average A1c level for population of patients with diabetes. A potential outcome reflecting access is number of days until 3rd next available appointment.³¹

An outcome that could spur interoperability (in an environment where about 75% of medical communications are conducted via fax)³² would be to require laboratory results to be attached to the claim where appropriate, for accurate tracking of chronic illness.

Issues and Caveats

There has been an alarming trend in contract consolidations, where contracts performing below bonus star levels have consolidated with contracts achieving 4 or more stars for the purpose of obtaining bonus payments. Higher performing contracts absorbed 1.4 million enrollees by the end of 2017, triggering the scrutiny of MedPAC. Over 20% of MA enrollees have been absorbed into higher performing contracts since 2013, resulting in bonus payments that would not have been received in absence of the consolidation. This results in higher payments to these contracts than warranted, fostering inequity between FFS and MA. From a Star Rating perspective, this means a large number of enrollees are in contracts that appear to be high quality, but in reality are not. These contract consolidations occur across state lines.

MedPAC's issues with MA consolidations appear to be addressed in the Bipartisan Budget Act of 2018 (effective 2019), but should still be monitored. CMS' proposed new rules that will

²⁹ Billings J, et al. Impact of Socioeconomic Status on Hospital Use in New York City. *Health Affairs*. 1993;12(1)162-73.

³⁰ Stiefel M, Nolan K. A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. Institute for Healthcare Improvement. 2012.

³¹ Institute for Healthcare Improvement. How to Improve: Science of Improvement: Establishing Measures.

³² Kliff S. The Fax of Life: Why American Medicine Still Runs on Fax Machines. 2018. Vox.com

calculate a weighted average of Star Ratings across contracts that have been consolidated to more accurately reflect quality, and mitigate quality bonus payments that are not warranted.

Star Ratings are assessed at the contract level. Reporting measures at the contract level is not as informative as plan-level data. Several stakeholders have recommended reporting at the plan level when possible, and at the contract level when plan-level data are not complete (i.e. for plans with lower enrollment). There are numerous plans in any given contract, so plan-level data on quality are more meaningful than contract-level data.³³ MedPAC continues to urge Congress to use the geographic unit for quality reporting- the local health care market area.

There are procedural improvements that could be addressed in the Star Quality ranking process. Most quality incentive programs in Medicare announce and implement changes after a formal rule-making process with a 60-day comment period. Stakeholders have requested CMS provide a full comment period to weigh in on program changes such as new measures or score calculation methodology. Similarly, the Star Ratings is the only program whose measure set is not finalized before the data are collected. Stakeholders have concerns regarding the calculation of thresholds for the Star Rating cut off points. The cut points (threshold values to use to assign Star Ratings for individual measures) are determined annually, and after the data have been collected, rather than before the measurement period.³⁴ This results in an unclear, moving target for MA contracts.

Categorical Adjustment Index (CAI) adjustments were integrated to adjust for socioeconomic status of enrollees, but the adjustment has minimal impacts on Star Ratings (4% of MA plans had their star rating increased due to CAI in 2016).³⁵ Plans serving high need enrollees with low incomes, chronic illness, or disabilities show significantly lower performance on Star Ratings metrics.³⁶

Recent adjustments in MA are allowing for more services related to health-related social needs. These services addressing major issues such as food insecurity and loneliness provide additional benefits likely to improve population health. This warrants broader outcomes measures to capture the effects of these investments, along the lines of CMS' Accountable Health Communities (AHCs). AHCs have measures to assess these outcomes. However, these benefits come with drawbacks, as advocates for choice and equity in Medicare have voiced concerns that these additional benefits, not available via FFS Medicare, bridge a divide in the access to services in the Medicare program.

Continuous quality improvement and innovating measurement to capture these improvements in individual and population health outcomes are essential for optimal health care. Stakeholders

³³ Johnson G, Lyon Z, Frakt A. Provider-Offered Medicare Advantage Plans: Recent Growth and Care Quality. *Health Affairs*. 2017;36(3):539-47.

³⁴ Anthem Public Policy Institute. Opportunities to Strengthen the Medicare Advantage Star Ratings Program. 2017.

³⁵ Teigland C, Donnelly P. The 2017 Medicare Star Ratings: How to Translate New CMS Data Into Future Successes. 2016.

³⁶ Teigland C, Donnelly P. The 2017 Medicare Star Ratings: How to Translate New CMS Data Into Future Successes. 2016.

including myself appreciate the Ways and Means Subcommittee on Health's attention to this critical matter.

Thank you.

2018 Part C & D Star Ratings Measures						
2018 ID	2017 ID	Measure	Primary Data Source	Improvement Measure	Weight	
C01	C01	Breast Cancer Screening	HEDIS	Yes	1	
C02	C02	Colorectal Cancer Screening	HEDIS	Yes	1	
C03	C03	Annual Flu Vaccine	CAHPS	Yes	1	
C04	C04	Improving or Maintaining Physical Health	HOS	No	3	
C05	C05	Improving or Maintaining Mental Health	HOS	No	3	
C06	C06	Monitoring Physical Activity	HEDIS / HOS	Yes	1	
C07	C07	Adult BMI Assessment	HEDIS	Yes	1	
C08	C08	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	Yes	1	
C09	C09	Care for Older Adults – Medication Review	HEDIS	Yes	1	
C10	C10	Care for Older Adults – Functional Status Assessment	HEDIS	Yes	1	
C11	C11	Care for Older Adults – Pain Assessment	HEDIS	Yes	1	
C12	C12	Osteoporosis Management in Women who had a Fracture	HEDIS	Yes	1	
C13	C13	Diabetes Care – Eye Exam	HEDIS	Yes	1	
C14	C14	Diabetes Care – Kidney Disease Monitoring	HEDIS	Yes	1	
C15	C15	Diabetes Care – Blood Sugar Controlled	HEDIS	Yes	3	
C16	C16	Controlling Blood Pressure	HEDIS	Yes	3	
C17	C17	Rheumatoid Arthritis Management	HEDIS	Yes	1	
C18	C18	Reducing the Risk of Falling	HEDIS / HOS	Yes	1	
C19	DMC22	Improving Bladder Control	HEDIS / HOS	No	1	
C20	DMC23	Medication Reconciliation Post-Discharge	HEDIS	No	1	
C21	C19	Plan All-Cause Readmissions	HEDIS	Yes	3	
C22	C20	Getting Needed Care	CAHPS	Yes	1.5	
C23	C21	Getting Appointments and Care Quickly	CAHPS	No	1.5	
C24	C22	Customer Service	CAHPS	No	1.5	
C25	C23	Rating of Health Care Quality	CAHPS	Yes	1.5	
C26	C24	Rating of Health Plan	CAHPS	Yes	1.5	
C27	C25	Care Coordination	CAHPS	No	1.5	
C28	C26	Complaints about the Health Plan	Complaints Tracking Module (CTM)	Yes	1.5	
C29	C27	Members Choosing to Leave the Plan	MBDSS	Yes	1.5	
C30	C28	Beneficiary Access and Performance Problems	Compliance Activity Module (CAM)	No	1.5	
C31	C29	Health Plan Quality Improvement	Star Ratings	No	5	
C32	C30	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)	Yes	1.5	
C33	C31	Reviewing Appeals Decisions	Independent Review Entity (IRE)	Yes	1.5	
C34	C32	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	Yes	1.5	
D01	D01	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	Yes	1.5	
D02	D02	Appeals Auto-Forward	Independent Review Entity (IRE)	Yes	1.5	
D03	D03	Appeals Upheld	Independent Review Entity (IRE)	Yes	1.5	
D04	D04	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	Yes	1.5	
D05	D05	Members Choosing to Leave the Plan	MBDSS	Yes	1.5	
D06	D06	Beneficiary Access and Performance Problems	Compliance Activity Module (CAM)	No	1.5	
D07	D07	Drug Plan Quality Improvement	Star Ratings	No	5	
D08	D08	Rating of Drug Plan	CAHPS	Yes	1.5	
D09	D09	Getting Needed Prescription Drugs	CAHPS	Yes	1.5	
D10	D10	MPF Price Accuracy	PDE data, MPF Pricing Files	No	1	
D11	D12	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data	Yes	3*	
D12	D13	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data	Yes	3*	
D13	D14	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data	Yes	3*	
D14	D15	MTM Program Completion Rate for CMR	Part D Plan Reporting	Yes	1	

* Note: for contracts whose service area only covers Puerto Rico, the weights for these measures will be zero in the summary and overall rating calculations and remain three for the improvement measure calculations.

Chairman ROSKAM. Mr. Toy.

**STATEMENT OF ANDREW TOY, CHIEF TECHNOLOGY OFFICER,
CLOVER HEALTH**

Mr. TOY. Chairman Roskam, Ranking Member Levin, and distinguished Members of the Committee, thank you for providing Clover Health the opportunity to share our views on the Medicare Advantage program.

I am Andrew Toy, the Chief Technology Officer for Clover Health. I oversee engineering and drive the vision for how technology can improve the lives of Clover's enrollees. I received my bachelor's and master's in Computer Science from Stanford University. And prior to Clover, I worked in Google's enterprise cloud division.

Clover Health began offering MA plans in 2013 and has grown to over 30,000 enrollees in several states. Our core business model is designed to rapidly generate new care delivery approaches and statistically measure their real-world effectiveness.

My testimony today will touch four key areas.

First, using data and technology to deliver high-quality care. Innovation and health improvement begins when we are able to drive enrollee engagement and promote healthy behaviors. Insurers should be developing approaches to managing patient care, rather than managing financial risk through pricing and utilization controls.

Clover believes that the MA program, combined with the application of data and technology, can uniquely deliver on the promise of increased value to Medicare enrollees. Our platform has the ability to compile data from varied sources, such as claims, electronic health records, and genomics, and weave them together to provide a much more comprehensive health profile. Clover can then apply our machine learning capabilities to extract key insights, such as predicting whether an enrollee is at a higher risk for admission to the hospital.

Generating insights from the health data of our enrollees is only useful if we are also able to affect their health outcomes. Clover is developing intervention protocols that do just this. For example, Clover has developed protocols that identify chronically ill patients, and provide them with at-home care. Another example: today, a large number of hospital admissions are due to adverse drug events. To reduce these risks, Clover will offer genomic testing to personalize each enrollees drug regimen at no cost to the patient.

We believe these three capabilities—compiling data, monitoring, and proactive intervention—have the potential to significantly improve enrollee health outcomes.

My second point today is on increasing competition and lowering barriers to entry. Even with the growth of MA plans over the last decade, there are still significant opportunities for future expansion and growth. Clover has a unique perspective on barriers to entering the MA market, and factors that inhibit market competition. Unlike start-ups in other industries, CMS's network adequacy regulations prevent us from providing our product overnight nationwide.

Satisfying adequacy standards may be useful to measure access in closed network models, but they are not a consequential measure of access in open, preferred provider organization plans. As a PPO, Clover allows our enrollees to choose any provider who accepts our enrollees and original Medicare. Permitting flexibility to CMS's existing network adequacy regime will encourage greater market competition and more new entrants in MA markets across the country.

CMS's requirement that plans maintain an adequate network of providers, specialists, and hospitals based on outdated "time and distance" standards may impede competition and growth, particularly in areas where providers and hospital systems have consolidated their market share. Thus, we urge policy-makers to focus on access and choice when evaluating network adequacy.

My third point is empowering patients with access to their personal health records. Clover applauds the recent focus and efforts to empower enrollees with control of their health care information. Creating a patient-centered model will allow enrollees to make much more informed decisions about their health. We support the Committee's efforts to allow enrollees to own, direct, and disclose their health data to whomever they choose, such as to a new provider, health plan, or health app.

Finally, we support recent policy changes that facilitate innovation and better health outcomes by allowing plan flexibility in supplemental benefits and telehealth, as well as changes to the risk adjustment program.

Thank you again for providing Clover Health with this opportunity, and it is an honor to be here with you today, and I look forward to your questions.

Chairman ROSKAM. Thank you.

[The prepared statement of Mr. Toy follows:]

**TESTIMONY OF ANDREW TOY,
SAN FRANCISCO, CALIFORNIA
BEFORE WAYS AND MEANS COMMITTEE
US HOUSE OF REPRESENTATIVES
DATE: TUESDAY, MAY 8, 2018**

Chairman Roskam, Ranking Member Levin, and distinguished Members of the Committee:

Thank you for providing Clover Health the opportunity to testify before the Committee and to provide our views on the Current Status of and Quality in the Medicare Advantage ("MA") Program.

I am Andrew Toy, the Chief Technology Officer of Clover Health ("Clover"). At Clover, I am responsible for overseeing engineering, data science, product, IT and security, and driving the vision for how technology and analytics can improve the lives of Clover's MA beneficiaries. Prior to Clover, I coordinated Google's enterprise activities for the Android team and ran machine learning, enterprise search and analytics for the Google Cloud G-Suite team. Before that, I was the CEO and co-founder of Divide, a company focused on creating a split between work and personal data on mobile devices, which was acquired by Google in 2014. I received my B.S. and M.S. in Computer Science from Stanford University, where I also served as an associate lecturer in computer science.

I joined Clover earlier this year to help advance the way Medicare beneficiaries are cared for. Clover does this by capturing and analyzing data to identify at-risk beneficiaries and to proactively intervene with services to improve health outcomes, fill care gaps, and reduce avoidable costs. Our business model is designed to rapidly generate new care delivery approaches and test their real-world effectiveness. In 2013, Clover began offering MA plans in New Jersey and has grown to over 30,000 enrollees. In 2018, the company expanded plan coverage to Georgia, Philadelphia, and Texas, with further expansion planned for 2019.

We appreciate that the Committee wants to hear about Clover's experiences as an emerging healthcare start-up focused exclusively on MA. Congressional leaders, together with the Centers for Medicare and Medicaid Services ("CMS"), have designed and overseen a MA program that offers beneficiaries the value of complex care coordination and management and high quality standards. My testimony is focused on four areas: (1) using data and technology to deliver high quality care to Medicare beneficiaries, (2) addressing barriers to MA growth, thereby encouraging robust competition in MA, (3) facilitating innovation and better health outcomes by allowing plan flexibility, and (4) supporting a continued focus on the individual right to health data.

I. Applying Data and Technology in Medicare Advantage

Innovation and health improvement begins when we are able to understand factors that drive beneficiary engagement and that promote the management of their chronic conditions so that we can proactively address preventable episodes of care. In other health organizations, researchers and clinicians are constantly reviewing and assessing whether a clinical program is working, or whether a medication adherence intervention results in an actual adherence uptick. The health insurance industry should be no different -- insurers should evaluate approaches to managing care and integrate successful preventive outcomes in their operations. However, the health insurance model is often reliant on managing costs through pricing and utilization controls such as benefit design rather than disease prevention.

As a new entrant to the health insurer market, Clover believes that the MA program -- and the application of data and technology -- can uniquely deliver on the promise of improved health outcomes for and value to Medicare beneficiaries. Clover's business model is built around rapid learning and iteration, and is focused on determining what actually works in a highly complex industry. We apply our learnings for the benefit of our membership and we employ a large team of data and research scientists to aid us in evaluating these questions.

Clover looks at data differently than others in the healthcare space. Health data can take different forms: claims data from hospital and provider visits, electronic health records with detailed provider notes, prescription fill history, or personalized genomic data. Clover's data platform has the ability to compile data from these varied sources and structure this information to provide a more comprehensive health profile of our beneficiaries. With this enhanced view of our beneficiaries, Clover can apply our machine learning capabilities that enable us to examine data for key insights, such as predicting whether a beneficiary is at risk for a medical condition or disease state.

Structuring and examining the health data of our beneficiaries is only useful if we're able to impact health outcomes. Clover is developing intervention protocols to address risks and to help manage and improve outcomes. For example, Clover has developed home care protocols for chronically ill patients, a program that allows at-risk beneficiaries to be seen in their homes by physicians. This ensures they are cared for and reduces friction for at-risk beneficiaries to be transported to, and seen at, provider offices or hospitals, thus preventing hospitalizations and increasing beneficiary satisfaction. We are launching another program where Clover will offer gene-informed medication management for in-home primary care members to reduce adverse drug interactions. For Medicare beneficiaries, a large number of hospital admissions are due to adverse drug events. To reduce these risks, Clover will perform pharmacogenomic testing to personalize each member's drug regimen at no cost to our enrollees. We believe the result of these three capabilities - compiling data, monitoring, and proactive interventions - is improved beneficiary health outcomes.

As Clover learns more about beneficiary behaviors and outcomes, we hope there will be opportunities for MA plans to partner with the Committee and with CMS to develop new models that will improve outcomes and contribute to high quality care programs. Any learnings produced by these programs would, of course, be shared back with CMS in order to benefit the overall Medicare population. We believe that our model will ultimately deliver meaningful data and evidence that can have a critical impact on understanding successful beneficiary interventions. Using this rich data, CMS and

health plans could develop scalable, dynamic and personalized programs for beneficiaries that achieve successful outcomes, while limiting those which only provide pecuniary gain.

II. Increasing Medicare Advantage Competition and Lowering Barriers to Entry By Addressing Network Adequacy

Even with the growth of MA plans over the last decade, there are still significant opportunities for further expansion and growth. The Congressional Budget Office estimates that Medicare Advantage enrollment will rise from 33 to 41 percent of all Medicare beneficiaries by 2027.¹ Yet according to a recent Commonwealth Fund study, there is little or no competition in MA insurance markets in 97 percent of U.S. counties.² The report also found that, of the 100 counties with the greatest number of Medicare beneficiaries, 81 lacked significant competition. Indeed, market competition is often the best way to motivate providers, hospitals, and health plans to increase efficiency, improve quality, and ensure that health care prices reflect the value of services provided to consumers.

As a new MA plan looking towards expansion, Clover has a unique perspective on barriers to entering the MA market and factors that inhibit market competition. Unlike many tech start-ups or incumbent health plans, we're not able to provide our product in all 50 states and territories overnight. At a minimum, entry into a MA market requires us to obtain state licenses (often not an issue) and to satisfy network adequacy requirements. Addressing the second factor, permitting flexibility to CMS' existing network adequacy regime will encourage greater competition, and new entrants, in MA markets across the country. CMS' requirements that plans maintain an adequate network of providers, specialists, and hospitals may impede competition and growth,

¹ Congressional Budget Office, "Medicare – Congressional Budget Office's January 2017 Baseline," January 24, 2017. Available at:

<https://www.cbo.gov/sites/default/files/recurringdata/51302-2017-01-medicare.pdf>.

² Brian Biles, Giselle Casillas, and Stuart Guterman, "Competition Among Medicare's Private Health Plans: Does It Really Exist," The Commonwealth Fund (Aug. 2015), <http://www.commonwealthfund.org/publications/issue-briefs/2015/aug/competition-medicare-private-plans-does-it-exist>

particularly in areas where providers and hospitals systems have consolidated their market share. MA plans are required to have enough providers in their network to ensure that beneficiaries can access care within specific “time and distance” standards. These time and distance rules vary substantially by specialty and county based on the number of beneficiaries and type of region. Satisfying adequacy standards may measure access in HMO and closed network models, but such standards are not a consequential measure of access in open Preferred Provider Organization (“PPO”) plans. Clover offers MA PPO products in our service areas, meaning that our beneficiaries can see any provider who accepts Original Medicare. Our beneficiaries have expansive options; they have the benefit of utilizing Clover’s hospital and provider network, or they can select another provider in Original Medicare. Consequently, beneficiaries experience broad access to care in Clover’s PPO plan, regardless of whether providers choose to contract with Clover. Rather than relying on outdated time and distance standards, we urge the Committee to consider beneficiary access and choice when evaluating network adequacy.

Congressional leaders, together with CMS, may consider developing a “standardized” health system contract for providers who refuse to contract with MA plans based on unreasonable financial demands. Hospital consolidation has given significant power to health systems to prevent MA plans from entering certain markets. Indeed, the Federal Trade Commission (“FTC”) and the States have challenged some potentially harmful hospital mergers that could threaten competition and harm consumers. Hospital systems with exclusive control in a geographic area will often require exorbitant pricing to contract and become “in-network,” which often results in increased MA premiums and out-of-pocket costs to consumers. We would propose a construct wherein, with regard to a health system that participates in Original Medicare but is unwilling to sign a payor agreement with a MA plan at 100% of the fee-for-service Medicare rate (keeping in mind these rates are already adjusted based on geography and economic factors), the MA plan should have the option of: a) deeming the health system out-of-network, or b) defaulting to a “standardized” Original Medicare

designated contract with such system and having the system be deemed in-network for purposes of network adequacy determinations.

Another approach to foster increased competition would be to establish network adequacy standards for MA plans as they enter new markets. For example, CMS could allow a 3-year “pilot” period in which a MA plan could enter a new market and make all reasonable efforts to develop a network that complies with the network adequacy standards. The plan would be subject to increased marketing transparency developed to ensure that beneficiaries are fully aware of any specific network limitations. During this time, assuming that the MA plan establishes a viable network that could attract beneficiaries, the MA plan would be able to show value to consumers and physicians in the geography, and thus, enable membership and network growth. This approach would lower the barriers for new market entrants for the purpose of increasing competition among MA plans.

III. Recent Policy Changes Supports Innovation

Clover shares the commitment by the Committee and CMS to transform the healthcare delivery system and the Medicare program. The 2018 Balance Budget Act, combined with CMS’ Final Rule affecting Part C and D Plans (“Final Rule”)³, moves the MA program forward and allows plans more flexibility to administer, and innovate on, the benefit offerings.

First, Clover welcomes the additional flexibility that MA plans now have to define the supplemental benefits offered to beneficiaries. As healthcare evolves to incorporate data on social and environmental determinants of health, health plans can evaluate whether benefits in transportation, nutrition, and housing can favorably impact health. Clover can combine these factors with our existing clinical information, and through our data analytics, potentially predict those beneficiaries that would be at greater risk for adverse events and generally worse health outcomes. Incorporating benefits to address

³ 73 Fed. Reg. 16440, “Medicare Program; Contract year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program,” Centers for Medicare and Medicaid Services (Apr. 16, 2018).

these determinants could serve to further decrease healthcare costs and improve quality of care.

Second, we support CMS' expansion of telehealth coverage under Medicare Advantage. We believe the wider telehealth availability will increase beneficiary access and quality of care, and reduce costs using technology that has long been readily available. We understand CMS will continue to monitor telephonic and virtual delivery of services -- such as in virtual coaching on weight management in the Medicare Diabetes Prevention Program. Clover encourages CMS to thoughtfully embrace high value, low risk interventions delivered through innovative forums and modalities that increase beneficiary satisfaction.

Third, CMS continues to evaluate the risk adjustment model (1) at the direction of the 21st Century Cures Act, and (2) to address transparency, flexibility, program simplification, and innovation. The Medicare Advantage risk adjustment program was created, among other reasons, as a method of adjusting bidding by and payments to health plans to reflect the additional costs of providing care to beneficiaries with more complex disease states and conditions. We applaud CMS' recent changes to the risk adjustment model, incorporating meaningful chronic conditions like mental health, substance abuse disorder, and chronic kidney disease. Additionally, the Committee should consider changes that would link health plan interventions or actions to the risk adjustment data. As MA plans (and their vendors) become more successful at gathering information and identifying diagnosis codes for purposes of risk adjustment, we encourage additional requirements by CMS to ensure such data will be used to advance beneficiary health and outcomes. At Clover, we have designed our data platform so that, when we document risk adjustment diagnoses, we better understand our beneficiaries, and we then apply that better understanding to deliver more customized care for them.

Finally, we appreciate CMS' continued focus on Medicare quality standards and recent efforts in the Final Rule to reassess the methodology for the Part C and D Star Rating system. The Star Rating remains a critical tool for beneficiaries to evaluate and

compare MA plans. Clover supports the existing Star Rating program and encourages the Committee and CMS to consider additional adjustments to the methodology that rewards plans with better health outcomes and with broad provider access and choice.

IV. Empowering Patients with Access to Personal Health Records

Turning to privacy policy, Clover applauds the recent focus and efforts to empower beneficiaries with control of their health care information. Creating a beneficiary-centered model -- whereby beneficiaries have full access to their personal health care data -- will allow them to make informed decisions about their health. In this patient-centric model, the health data should move with the patient. We support regulations and legislation that allows the patient to own, direct, and disclose their health data to whomever they choose, such as to a new provider, health plan, or health app.

To that end, Clover is interested in working with the Committee on drafting a simple and meaningful individual consent and notification process for access to health information across federal entities. Today, health plans must obtain multiple consent forms and notifications to share data. This process requires plans to offer CMS forms, HIPAA authorizations, and appropriate FTC notifications. Foundational consenting documents should be simple, clear, and concise, enabling our beneficiaries to understand their rights to privacy and allow them to take personal charge of their health care data.

Thank you again for providing Clover Health with the opportunity to testify before Congress and provide our views.

It has been an honor to be here with you today. If you have any questions, I will be happy to answer.

Chairman ROSKAM. Ms. Klausner.

**STATEMENT OF DAPHNE KLAUSNER, SENIOR VICE
PRESIDENT, SENIOR MARKETS, INDEPENDENCE BLUE CROSS**

Ms. KLAUSNER. Chairman Roskam, Ranking Member Levin, and Members of the Subcommittee, good morning and thank you for the invitation to testify at today's hearing.

My name is Daphne Klausner, and I am the Senior Vice President for Senior Markets at Independence Blue Cross in Philadelphia. Through our parent organization, Independence Health Group, we serve over 8 million people in 24 states and the District of Columbia.

Chairman ROSKAM. Ms. Klausner, can you pull the mike just a little closer?

Ms. KLAUSNER. Yes, I am sorry. Is that better?

We are the leading Medicare Advantage plan in southeast Pennsylvania, where we have served the community for nearly 80 years. Our 100,000-plus Medicare Advantage members live in a diverse region that includes the poorest large city in America, as well as several academic medical centers. High demands for Medicare Advantage have prompted unprecedented competition in certain markets, including Philadelphia, where 14 insurers offer products in 2018.

We welcome competition, and we responded by offering a zero-premium product with additional benefits not found in traditional Medicare, such as hearing aid coverage, fitness benefits, and a 24-7 nursing hotline, all while our members are protected by limits on their out-of-pocket costs. Affordability, added benefits, and greater care coordination are driving the program's popularity nationwide.

Medicare Advantage plans provide better quality and lead to better health outcomes. These successes are based on recent legislative reforms that came from this Committee, as well as many of the regulatory changes CMS made for 2019. Together, these policies show the Federal Government's commitment to affordability, innovation, and flexibility.

As an example of innovation, at the direction of Congress, CMS is now encouraging the expansion of telemedicine platforms. This will give people access to on-demand care at home or while traveling. On April 19th, Independence announced a new partnership with Comcast to develop a patient-centered portal that includes telemedicine services and other digital health features that will connect patients, doctors, and care-givers.

An example of flexibility, policy changes from Congress and CMS will allow plans to offer additional supplemental benefits, and reduce cost-sharing to our most vulnerable members with chronic conditions. These changes will allow plans to work more closely with the provider community and local organizations. At Independence, our goal is to use innovative plan designs to focus more heavily on the social determinants of health that impact our members.

For example, Independence is exploring a nutrition benefit for newly-discharged hospital patients, since shopping for groceries and cooking might be impossible for a senior recovering from a hospital stay. In addition, an estimated 3.6 million Americans forgo medical care because they lack access to transportation. Plan de-

sign flexibility will allow us to better address individual patient needs.

We are also pleased that CMS, Congress, and other key stakeholders are committed to improving the data system. Although the system is improving, CMS and Congress should curtail the use of this data for payment purposes until processing times improve and plans have more clarity on how submissions are adjudicated.

Furthermore, Independence agrees that the value-based intent of the Star Rating System, which ties reimbursement to measurable performance on over 40 clinical and patient experience metrics, has been responsible for a profound reorganization in how plans operate.

But the program needs reforms to make the scoring process more reflective of true quality to help beneficiaries interpret meaningful differences between plans. We encourage CMS to continue focusing on Star measures that push plans and providers to collaborate on improving patient health outcomes.

In closing, we strongly support the policy changes Congress and CMS have made to grant plans like ours more flexibility to address social inequities in health and provide coordinated care in a more holistic way. We agree with the efforts to accelerate the transition to value-based payment, as we move away from a volume-based system.

On behalf of Independence Blue Cross and our CEO, Dan Hilferty, I would like to thank the Members of this Committee for the opportunity to share my thoughts with you today. We are excited to be a part of this important discussion and look forward to working with you to ensure the continued success of the Medicare Advantage program. Thank you.

Chairman ROSKAM. Thank you.

[The prepared statement of Ms. Klausner follows:]



**HEARING BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES
WAYS AND MEANS SUBCOMMITTEE ON HEALTH
May 8, 2018**

**Written Testimony of Daphne Klausner
Senior Vice President for Senior Markets, Independence Blue Cross**

Chairman Roskam, Ranking Member Levin, and members of the subcommittee, good morning and thank you for the invitation to testify at today's hearing on "The Current Status of and Quality in the Medicare Program." My name is Daphne Klausner and I am the Senior Vice President for Senior Markets at Independence Blue Cross based in Philadelphia, Pennsylvania. Through our parent company Independence Health Group, we serve 8.4 million people in 24 states and the District of Columbia.

In the Medicare Advantage market, we are proud to be the most popular plan in Southeast Pennsylvania, where we have served the community for nearly 80 years. Our 100,000+ members live in a diverse region that includes the poorest large city in America as well as several world class academic medical centers that we partner with as part of our collaborative Facilitated Health Network. These include the University of Pennsylvania, Temple University, and Jefferson Health System. As we transition to greater reforms that incentivize value over volume, we believe we offer a unique perspective in this important debate.

**Growth and Value of Medicare Advantage is Well Documented**

I have been working in the Medicare market at Independence for 23 years and have been amazed by the progress made since the demonstration programs of the 1990s to what Medicare Advantage is today. Nationally, about one-third of all Medicare beneficiaries – over 21 million Americans – choose Medicare Advantage over traditional Medicare, an increase of 70 percent since 2010. If these trends continue, estimates suggest that the program will account for 42 percent of all beneficiaries in less than ten years¹. Other factors, such as the policy changes prohibiting first dollar coverage in Medicare supplemental plans under MACRA, will likely accelerate this growth.

This demand has prompted unprecedented competition in certain markets, including Philadelphia, where 14 health insurers offered products during the 2018 open enrollment cycle. We welcome competition because it is good for consumers and we responded by offering a new, zero-premium product across our entire coverage area with additional benefits not found in the traditional Medicare program. This product includes hearing aid coverage, a fitness benefit, and a 24/7 nursing hotline – all while our members continue to be protected by limits on their out-of-pocket costs, which traditional Medicare does not provide.

Affordability, added benefits, and greater care coordination are driving the program's popularity nationwide. Studies continue to show that Medicare Advantage plans are providing better quality and leading to better health outcomes. A recent peer-reviewed study published in Health Services Research found that Medicare Advantage plans outperformed traditional

¹ Congressional Budget Office (CBO) Medicare Baseline. April 2018.

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Medicare on 16 different clinical quality measures, including preventative screenings and nine other measures of care and service². Further, MedPAC's December 2017 status report concluded that payments to plans are now roughly in line with traditional Medicare, making the program a cost-effective use of taxpayer dollars³.

Recent Congressional and CMS Policy Reforms Show Commitment to Program's Success

We are optimistic that these successes will only continue based on the recent legislative reforms that emanated from this committee as well as many of the regulatory changes promulgated by CMS for the 2019 plan year. Collectively, these policies demonstrate the federal government's programmatic commitment to affordability, innovation, and flexibility.

On affordability, we were pleased that Congress acted to suspend the Health Insurance Tax (HIT) for 2019. The HIT is in effect this year and has put added pressure on premiums, cost-sharing and benefits. According to an October 2017 study by Oliver Wyman, the tax equates to \$245 per enrollee⁴. That burden has been lifted for 2019.

On innovation, CMS is now developing telemedicine guidelines at the direction of Congress in order to expand the availability of these services in the Medicare Advantage program nationwide. Telemedicine platforms, which are commonly used today in commercial employer plans, will give beneficiaries access to on-demand clinical care in their own home or

² Health Services Research: "Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures." Volume 52, Issue 6 (December 2017).

³ Medicare Payment Advisory Commission (MedPAC). "Medicare Advantage Program: Status Report" [presentation]. December 2017.

⁴ Oliver Wyman. "How the ACA's HIT Will Impact 2018 Premiums." October 10, 2017.

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while on the go. On April 19th, we announced a new partnership with Comcast to develop a patient-centered portal that will include telemedicine capabilities alongside other digital health features. Our goal is to have these technologies improve access to primary and preventive care, ultimately reducing preventable ER visits and hospital readmissions.

On flexibility, policy changes from Congress and CMS will allow plans to offer an array of supplemental benefits and reduced cost-sharing to our most vulnerable members with chronic conditions. Recent policy changes will enable plans to work more closely with the provider community and local community organizations to ensure our members select the most appropriate plan and obtain clinical care while reducing their cost-sharing obligation. Such changes, like lowering out-of-pocket costs for diabetic supplies or waiving a copay to see a certain specialist, will hopefully improve beneficiary outcomes and generate cost savings in the long term.

We're hopeful that these reforms, in addition to others not listed here, will spur new models of care management that increase value for Medicare Advantage beneficiaries and taxpayers. At Independence, our goal is to use innovative plan designs to begin focusing more heavily on the social determinants of health that can impact our members as much as medications or wellness visits do now. We were encouraged to see CMS recently issue guidance on the types of new supplemental benefits that plans could offer in the future, including home

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improvement services to prevent falls, adult day care services, and caregiver support, to name just a few⁵.

For instance, Independence is exploring the possibility of offering a nutrition benefit for recently discharged hospital patients. Shopping for groceries or attempting to cook can be extremely difficult for a senior recovering from an acute inpatient stay. Lack of access to quality meals and the struggle to secure them can impede a patient's recovery. Research studies, including one by the Metropolitan Area Neighborhood Nutritional Alliance (MANNA), a local non-profit in Philadelphia, have shown that increased access to nutrition services can decrease hospital readmissions and improve patient outcomes⁶. Access to transportation is often identified as another barrier to care, with an estimated 3.6 million Americans foregoing medical care due to this obstacle⁷. We hope to more adequately address transportation needs for our members thanks to the new flexibility in benefits.

Ongoing Areas for Collaboration***Encounter Data***

Independence remains excited about the future and we know there are areas where additional collaboration between CMS and plans will enhance quality and value for our members. We are pleased that CMS, members of Congress, and other key stakeholders are aware of the debate surrounding the Encounter Data System (EDS) and are committed to exploring

⁵ CMS: "HPMS Memo Uniformity Requirements" (Guidance on MA Benefit Design Flexibility). April 2018.

⁶ Journal of Primary Care & Community Health: "Examining Health Care Costs Among MANNA Clients and a Comparison Group." June 2013.

⁷ American Hospital Association: "Social Determinants of Health Series: Transportation." November 2017.

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ways to improve it. We support the goal of the EDS system, which is to increase transparency and more accurately compensate plans for the relative health risks of their members.

Recent reports published by the Government Accountability Office (GAO) and the HHS Office of Inspector General (OIG) have documented implementation concerns with the use of the EDS as a source of diagnosis for risk adjustment purposes⁸⁻⁹. As the Blue Cross and Blue Shield Association indicated in its comments to CMS in March, plans remain in the dark about how certain claims are translated into the system, and they are generally frustrated with the long lag time between when plans submit data and when the agency can render a decision about how it will be used for risk adjustment purposes.

CMS has reissued these return files – called ‘MAO-004 reports’ – multiple times in the past two years. We continue to believe that, since CMS issues the MAO-004 report on a monthly basis – in contrast to other risk adjustment return files, which are provided on a daily basis – we cannot identify errors in EDS and resubmit data in a timely fashion. Furthermore, CMS could improve the process through which encounter data payment and operational issues are approached by having regular, transparent, and structured collaboration with the industry.

While we recognize that the EDS system is improving, it may be prudent for CMS and Congress to curtail the use of this data for program payment purposes until processing times improve and plans have more clarity on how submissions are adjudicated. Otherwise, the EDS

⁸ GAO. “Medicare Advantage: Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments.” January 2017.

⁹ OIG: “Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed.” January 2018.

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system could act as an arbitrary reduction in funding to the program, which was not its intended goal.

The Star Rating System

Independence applauds the value-based intent of the Star Rating System, which ties reimbursement to measurable performance on over 40 different clinical and patient experience metrics. This has driven a profound reorganization in how plans operate. For example, it has solidified our role as partners in care working with our provider community to ensure that necessary screenings take place, chronic conditions are properly managed, and readmission rates are being curbed, all of which promote better health for beneficiaries.

Nevertheless, the program is in need of reforms that will enable the scoring process to be more reflective of true quality in a way that helps beneficiaries interpret meaningful differences between plans. We encourage CMS to develop new Star measures that push plans to continue improving their members' health outcomes. At the same time, the agency should also consider reorienting how it calibrates the existing measures.

For this we recommend three actionable policies. First, we urge CMS to retire "topped out" measures on which almost all plans are doing exceedingly well, and where differences among plans are not statistically significant. Our second recommendation is to consider regional adjustments for Star Ratings, which may better account for differences in beneficiary populations. Regional adjustments could also provide additional information to beneficiaries on local performance of national contracts. Lastly, while member experience is an important factor

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for indicating quality, the customer (CAHPS) surveys conducted by CMS are not always the most useful proxy. Our experience has been that the questions are subjective, the surveys are conducted on paper, and they are sometimes sent to members in different plans by mistake. In short, they do not give plans meaningful feedback on how to improve quality or the beneficiary experience, despite accounting for 17 percent of a plan's Star score – a disproportionate weight for these measures.

That said, we look forward to learning more about CMS's proposal to create a technical expert panel of representatives from various stakeholder groups to offer input on the program's framework, measures, and methodology. Additionally, the agency's plan to implement material changes through the formal rulemaking process as opposed to the annual call letter will enable greater dialogue and afford plans more time to operationalize changes.

In closing, we want to reiterate how pleased we are with many of the policy changes Congress and CMS have made recently to allow plans more flexibility in addressing social determinants of health and providing coordinated care for our members in a holistic way. We also applaud the efforts to accelerate the transition to value-based payment as we move away from a volume-based system. We are eager to see how future program reforms can enable plans to continue improving our members' experience, health, and wellbeing.

On behalf of Independence Blue Cross and our CEO Dan Hilferty, I want to thank the members of this Committee for the opportunity to share my thoughts with you today. We are excited to be part of this important discussion and we look forward to working with

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all of you to ensure the continued success of the Medicare Advantage program. Our seniors are counting on us.



Chairman ROSKAM. Mr. Hoadley.

**STATEMENT OF JACK HOADLEY, PH.D., GEORGETOWN
UNIVERSITY HEALTH POLICY INSTITUTE**

Mr. HOADLEY. Thank you, Mr. Roskam, Mr. Levin, and Members of the Subcommittee. I am Jack Hoadley, a Research Professor at Georgetown University, and I appear today both as a Medicare researcher and a Medicare beneficiary. I also recently completed six years on the Medicare Payment Advisory Commission, MedPAC. I do not speak on behalf of Georgetown or MedPAC, but only for myself. I appreciate the opportunity to share my perspectives about Medicare Advantage and the Medicare Plan Finder.

Medicare is a critical element of our nation's social insurance framework because Medicare provides health coverage to nearly 60 million beneficiaries with diverse backgrounds, situations, and needs. It is a significant challenge to educate beneficiaries about the program in general and about Medicare Advantage plan options.

Notably, it is time to make improvements to the online Medicare Plan Finder, a valuable tool that needs significant modernization to do that job better. All of us who are Medicare beneficiaries need to be well-informed about our options. If we do not know key insurance terms like "deductibles" or "co-insurance," if we do not understand the various parts of Medicare or the rules around supplemental insurance, such as Medigap, if we do not learn about the benefits and provider networks for different MA plan options, then we are at risk. Misunderstandings about how Medicare works can lead to costly decisions.

Research tells us that Medicare beneficiaries tend to purchase more protection than they need and focus more on plan premiums than on total costs. Also, while consumers value choice in purchasing insurance, too many choices can lead to information overload and missed opportunities to save money or switch to plans that would serve their needs better.

The Medicare Plan Finder has been a neutral and unbiased resource from beneficiaries for over a decade, helping us make choices about the program. Yet, a new report the Chairman mentioned, "Modernizing Medicare Plan Finder," recently released by the Clear Choices Campaign and the National Council on Aging, recommends that the program must be improved and modernized to incorporate the best e-commerce practices.

This report drew upon interviews with beneficiaries as they navigated the Plan Finder, a survey of directors of state health insurance assistance programs, or SHIPs, and review of all online Plan Finder functions. The report found that today the Plan Finder is overwhelming, and information is poorly presented. This leaves beneficiaries confused; it can contribute to poor decision-making. Let me elaborate.

Firstly, modernizing the Plan Finder requires redesigning it to make the layout more user-friendly and more intuitive. For example, every time a user wants a definition for an insurance term, it opens a new tab on your browser. We find that some consumers end up with 20 to 30 open tabs. This is not helpful. Replacing insurance jargon with plain language is also critical, and adding a

web chat function could help offer people quick and accurate answers.

Secondly, when comparing choices among MA plans or between MA and traditional Medicare, beneficiaries want an accurate estimate of their total out-of-pocket costs, and they want that comparison to include the effect of supplemental Medigap coverage on their cost if they are in traditional Medicare, something the Plan Finder does not do today. It should also help beneficiaries understand the limitations on their ability to regain Medigap coverage if they join an MA plan and decide to leave that plan in the future.

Thirdly, if results can be personalized, they will serve consumers better. While a perfect prediction of next year's costs is, of course, impossible, incorporation of information on health status, drugs currently used, and expected use of other services could help provide people with better estimates.

Fourthly, a serious gap is the lack of an integrated provider directory. Today, if you request information on whether your physician or other health care provider is in an MA network, this requires leaving the Plan Finder to navigate the plan's web site. This is a confusing extra step for people, and we found that people failed to do that, or got confused when they tried to do that. The Plan Finder is better at allowing you to find out whether your drugs are on a plan formulary, and the Plan Finder needs to build that same capability for getting information about providers into the system, and to make sure that information is accurate.

Fifthly, Star Ratings play a key role, but many think that Star Ratings are really just user reviews like they are accustomed to for restaurants and movies. CMS needs to convene a panel of beneficiaries and stakeholders to evaluate which Star Ratings are important, and how best to explain them.

Finally, one reason the Plan Finder can be hard to use when comparing plan options is the wide variation in benefits and features used by different MA plans. I have long advocated greater standardization in both the benefits plans offer and the information used to describe them. Plans should be encouraged to innovate and add new features, but variations that are not meaningful can confuse more than they help.

To conclude, all of us who are Medicare beneficiaries need accurate information and the ability to compare our Medicare options. This is critical to making an optimal choice, one that saves on out-of-pocket costs and enrolls us in a high-quality Medicare option that suits our needs. Savings for Medicare beneficiaries also translate to savings to taxpayers. We have an opportunity today to invest in a modernized Plan Finder that will better serve the needs of all beneficiaries.

Thank you.

Chairman ROSKAM. Thank you.

[The prepared statement of Mr. Hoadley follows:]

**Medicare Beneficiaries and Medicare Advantage:
Modernizing the Plan Finder and Other Educational Tools**

**Statement of
Jack Hoadley, Ph.D.**

**Research Professor Emeritus
Health Policy Institute, McCourt School of Public Policy
Georgetown University**

**Before the
House Committee on Ways and Means, Subcommittee on Health**

May 8, 2018

Good morning, Mr. Chairman, Ranking Member, and Members of the Subcommittee. My name is Jack Hoadley, and I am a Research Professor Emeritus at Georgetown University's McCourt School of Public Policy. I know the Medicare program from three perspectives. First, as a researcher, I have published extensively on Medicare Part D and Medicare Advantage (MA). Second, I served as a Commissioner on the Medicare Payment Advisory Commission (MedPAC) for the past six years. Third, I am a Medicare beneficiary. In today's testimony I speak for myself and not on behalf of Georgetown or MedPAC.

I appreciate the opportunity to speak to the Committee about Medicare Advantage, the Medicare Plan Finder, and other issues related to beneficiary education. I regard Medicare as a critical program for its nearly 60 million beneficiaries and a key element of our social insurance framework. Because Medicare has many different elements and beneficiaries come to the program with diverse backgrounds, situations, and needs, Medicare has a significant challenge to educate beneficiaries about the program in general and about Medicare Advantage plan options. Notably, it is time to make improvements to the Medicare Plan Finder—a valuable tool that needs significant modernization.

Background

Most individuals become eligible for Medicare when they turn 65; the main exception is those with significant disabilities can become eligible at a younger age. For many years, this meant that eligibility for Medicare and Social Security coincided at age 65. But starting with individuals born in 1938, full Social Security eligibility has been separated in time from Medicare eligibility as the age for full Social Security benefits has increased. Moreover, the timing varies further for two other reasons. For many who continue working beyond age 65 in a job with health benefits, employment-based coverage remains their primary coverage with Medicare being the secondary payer. And everyone eligible for Social Security has the option to start those benefits as early as age 62 and as late as age 70.

These variations mean that education about Social Security benefits does not routinely coincide with education about Medicare; nor can enrollment in both programs be accomplished at the same time. For Medicare beneficiaries interested in MA plans, their introduction to the available opportunities will vary depending on their situation. It does not occur at a uniform time for everyone.

Education about Medicare is critical because many consumers do not have all the information they need to make Medicare program choices that will best serve them. At the most basic, many consumers do not fully understand concepts such as coinsurance, deductibles, or other terms used to describe their health insurance options. Nor do they appreciate the implications for their out-of-pocket responsibilities. Even if they have achieved the health literacy to navigate options provided by their employment-based coverage or coverage through the ACA marketplaces, they find that some Medicare options and terminology (Medicare Parts A and B, the separation of drug coverage, the role of supplemental coverage, etc.) are different than those they were familiar with for private coverage. Misunderstandings about these program parameters can lead to costly decisions.

Evidence indicates too that consumers do not always make informed health decisions. Consumers tend to purchase more protection than they need and to focus more on plan premiums than on their total costs. While these decisions may be appropriate in some situations, often consumers are spending more than they need to spend. An additional complicating factor can be the choice environment facing Medicare beneficiaries. Consumers tend to value choice when they purchase insurance. But when consumers have too many choices, regardless of their level of health literacy, information overload is likely to work against good decision making. Often this translates to missed opportunities to save money or to switch to MA or Part D plans that would serve their needs better.

Today one of every three Medicare beneficiaries is enrolled in a Medicare Advantage plan. But understanding the key differences between traditional Medicare and MA remains difficult. One challenge is understanding options for Medicare supplemental (Medigap) insurance and employer-sponsored retiree coverage, both of which have implications for decisions about choosing between MA and traditional Medicare. For example, beneficiaries who switch from an MA plan to traditional Medicare may not have a full range of options for reacquiring a Medigap plan or employer-sponsored coverage. They may discover that Medigap plans are only available if they do not have preexisting conditions or that premiums are substantially higher because of their age or health status.

The remainder of my testimony focuses on the critical educational tools available to Medicare beneficiaries, especially the online Medicare Plan Finder operated by the Centers for Medicare & Medicaid Services (CMS).

Examining the Medicare Plan Finder

The Medicare Plan Finder has been a key resource for Medicare beneficiaries for over a decade. It is a key tool used by beneficiaries to educate themselves about the Medicare program in general, but especially to research and find the MA or Part D plan that is best for their personal situation. A report, “Modernizing Medicare Plan Finder,” released in April by Clear Choices and the National Council on Aging,¹ provides an evaluation of the Medicare’s online comparison shopping experience

¹ <https://www.ncoa.org/public-policy-action/health-care/better-coverage-choices/medicare-plan-finder-report/>

and offers a set of recommendations for modernizing and improving that experience. As part of the multi-stakeholder Improving Medicare Markets Initiative advisory group, I provided input and comments for the report.

The report drew on three sources of analysis and information: a review of all online Plan Finder functions, a set of interviews conducted with beneficiaries as they navigated the Plan Finder, and a survey of Medicare State Health Insurance Assistance Program (SHIP) directors.

Over more than a decade, the Plan Finder has provided beneficiaries a neutral and unbiased tool to learn about their Medicare options and to compare plans. Although it has fulfilled that role well over the years and incorporated many improvements, the Clear Choices/NCOA report found that the Plan Finder today is “overwhelming, information is poorly presented, and the user design is potentially misleading—all of which confuses beneficiaries and can contribute to many making poor plan selections.” The report concludes that the Plan Finder “must be improved” and that “functional improvements based on the best and common e-commerce practices should be made as quickly as possible.”

One key theme of the report’s recommendations is that the Plan Finder needs to be modernized. This includes an overall redesign of the layout and display to make it more user-friendly and to make navigation through the stages of the Plan Finder more intuitive. For example, when a user wants to look up the definition of a term, the site displays definitions on a separate glossary tab instead of a pop-up when the user hovers over the term. Researchers evaluating the Plan Finder for the report found that some consumers had 20 to 30 open tabs just from clicking on unfamiliar terms.

Related improvements should include replacing insurance jargon with plain language as much as possible and using supplemental graphics and charts where appropriate. The website will also benefit from a web chat feature to allow consumers to get clear answers to their questions and to get online counseling. Of course, this web chat function needs to be done well and ensure that consumers get accurate answers. In addition, the Plan Finder should also provide more information on how to connect to human support, such as SHIP counselors, for assistance.

Consumers want a plan finder tool to help them understand their out-of-pocket costs, whether they are comparing different MA plan options, comparing MA plans with traditional Medicare, or comparing drug costs in different Part D plans. When comparing MA plans with traditional Medicare, they also want the ability to compare their costs under the combination of traditional Medicare with Medigap to their costs in an MA plan—a comparison that is not available today.

Some cost information is available today, but the results may include percentages (such as coinsurance rates) where people want dollar estimates. And accuracy is critical. For example, some beneficiaries report that the drug costs reported on the Plan Finder do not always match the actual costs charged at the pharmacy.

When results can be personalized, they will serve consumers better. A perfect prediction of next year’s costs is never going to be possible. But if the Plan Finder can incorporate information on health status, drugs currently used, and expected use of other health services, estimates of out-of-pocket costs will be more accurate. Greater personalization would benefit other consumer education

documents as well. The Annual Notice of Change that all plans must send to current enrollees would be more effective if it tailored information to match the services and providers used by each enrollee.

One serious gap in the current Plan Finder is the absence of an integrated provider directory. Today getting information on whether your physician or other health care provider participates in a MA plan network requires leaving the Plan Finder website to navigate the plan's website. This extra step is confusing, and consumers often fail to follow this procedure. When they do, they discover that navigation on plan websites is not standardized—another source of confusion. The Plan Finder has been reasonably successful in offering the user the ability to use this tool to check on whether their drugs are covered by a specific plan and at what level of cost sharing. This makes searching and plan comparisons much easier. Accomplishing the same ability to learn whether a beneficiary's providers are in a plan's network is a key need, as is providing accurate information on which providers are accepting new patients. An integrated directory will require ongoing updates and accuracy checks throughout the year.

Over time, the Medicare Plan Finder has made greater use of the star ratings that measure several domains of plan quality and performance. Although star ratings are valued by beneficiaries, we have heard that people think they are solely based on user reviews like those found on restaurant or movie rating websites. The report recommends that CMS engage a panel of beneficiaries and stakeholders to evaluate which star ratings are most important to consumers and how to explain what they mean.

One reason the Medicare Plan Finder can be hard to use when comparing MA plan options is the wide variation in benefits and features offered by different MA plans. I have long advocated greater standardization in both the benefits offered by MA plans and the information used to characterize plans.² Plans should be encouraged to innovate and introduce new features, but variations that are not meaningful are likely to confuse more than help. Where differences exist, the challenge to the Plan Finder should be to find better ways to standardize the reporting of key information.

The Bottom Line

All of us who are Medicare beneficiaries need accurate information and the ability to make comparisons among our different Medicare options. This information is critical to making optimal choices. An optimal choice generally means low out-of-pocket costs and enrollment in a higher quality Medicare option that suit our needs. In most cases, savings for Medicare beneficiaries translates to savings to taxpayers as well.

Investments in modernizing the Medicare Plan Finder will be investments in a Medicare program that better serves the needs of all beneficiaries. We have an opportunity today to modernize the Plan Finder as well as other tools that help to educate beneficiaries.

² E. O'Brien and J. Hoadley, Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice, April 2008, <http://www.commonwealthfund.org/publications/issue-briefs/2008/apr/medicare-advantage-options-for-standardizing-benefits-and-information-to-improve-consumer-choice>

Chairman ROSKAM. Well, let's invite our Members to inquire. Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman. You know, one of the things I hear from the folks in my district is that they want to have a choice in where they get their health care from. In other words, it means that folks want insurance plans that have a broad network of providers.

You know, over a quarter of my constituents who are eligible for Medicare have Medicare Advantage plans. And these folks deserve to have a wide range of providers they can choose to see.

Mr. Toy, you mentioned that Clover Health is having problems contracting with certain health systems and provider groups in some areas because of a lack of local competition. I understand this is driven by consolidation within the health provider industry. Can you tell me if this is something you are seeing more frequently, and how it is impacting the cost and delivery of care?

Mr. TOY. Thank you for the question. This is definitely something we are seeing. As a new plan entering into a lot of markets, we have to fulfill network adequacy with CMS in order to even offer our plan.

And what we see is that when we go to see provider groups, especially if they are consolidated, especially if they have a lot of market share in a particular area, they have leverage which enables them to ask very high prices, or basically, to have us pay them a lot of money for them to be part of the in-network offering. This means that we either have to agree and then pay a lot—and make things very expensive for the folks on the plan in that area, or we have to basically not agree, and then we don't have network sufficiency, as per CMS rules.

So this is a very difficult situation to be in. This is often the case, like I said, when the provider has a lot of leverage in a given market. And so we are definitely seeing that.

Mr. JOHNSON. Ms. Klausner, I would ask you the same question. Can you respond, please?

Ms. KLAUSNER. Yes. I mean Philadelphia is a unique market, in that we have many, many providers, many academic medical centers, many hospitals, many physicians. I would say because of the history of my plan in particular, we have had a relationship with most of these providers for a long time. We have been in the business for 80 years. We have good relationships with our providers.

I think that what we are seeing in our market is that our providers are being more collaborative with us, transferring to value-based payments. So we see a positive relationship between the providers in the Philadelphia market.

And so, unlike Mr. Toy, in which New Jersey is a little more challenging—we were in the New Jersey market for a little bit—in Philadelphia, we are not seeing exactly the same thing. But we are seeing much better collaboration between the provider community and the health plans.

Mr. JOHNSON. And do you see that different in every state?

Ms. KLAUSNER. We operate only in the five-county Philadelphia area, so I can't comment on that.

Mr. JOHNSON. Okay. Thank you, Mr. Chairman.

Chairman ROSKAM. Mr. Levin.

Mr. LEVIN. Thank you. Usually when we have panels, there is a lot of disagreement. So I am searching to see if there are different perspectives.

Mr. Hoadley, you talked about the problems with the Plan Finder. Is there any disagreement among the four of you on his suggestions?

Ms. KLAUSNER. No, we actually agree wholeheartedly. Plan Finder should be modernized to be a little more intuitive and helpful to beneficiaries. The way it does work is very confusing.

Mr. TOY. I will also agree. And in this case, I would also point out that as we try to do more innovative things with the plans, as things tend to diverge a little bit more, as we experiment, it will be harder for something like the Plan Finder to keep up with that in its current state.

Ms. MORTENSEN. I agree, as well. As Mr. Hoadley is saying, these metrics are being perceived more as a Yelp review, as opposed to the quality metrics that are going into it. Everything I just advocated for is not having the intended effect on the end user.

Mr. LEVIN. Okay. Now, CMS has recently allowed more flexibility in plan design. That can increase the complexity. Why don't you four discuss that for a minute?

Mr. Hoadley, do you want to discuss it and we will go down the row quickly?

Mr. HOADLEY. Sure, thank you. Yes, I think the idea of adding more flexibility adds more opportunities to try innovative things, but it does potentially introduce complexities and thus confusion for beneficiaries.

If beneficiaries are trying to understand there is this additional benefit in this plan, this other plan has these benefits, and the third plan has something completely different, and there are different prices associated with those plans, it is hard to make comparisons. We should find a balance between the right amount of new ideas and ways to keep enough standardization so that we make sure that people can understand and make wise choices when they are evaluating their options.

Mr. LEVIN. Ms. Klausner.

Ms. KLAUSNER. I would say that the ability to be flexible with the benefits is probably one of the best things that has happened to the Medicare Advantage system since I have been in this business, which has been for 23 years, working in Medicare Advantage.

You know, in our particular plan, we have Philadelphia, which is a large, poor city. We have surrounding suburban communities which have a wealthier population. The ability to have different plan offerings and benefits to address the particular needs of the different constituents in those particular areas is really important for us.

You know, I talked a little bit in my testimony about social determinants of health and how important that is. To be in a large city where we have a lot of people living alone, a lot of people at the poverty level, and a lot of people who don't have, for instance, dental care, which is something that we are trying to figure out as a plan for the 2019 bid, is really important to us, and I think is also very important to a lot of different beneficiaries.

Mr. LEVIN. We have legislation to provide within Medicare for everybody that benefits. It would seem to me that what you say makes that wise.

Mr. Toy.

Ms. KLAUSNER. I—

Mr. LEVIN. Excuse me.

Ms. KLAUSNER. Sorry. I think being able to offer a dental benefit to every Medicare beneficiary would be extraordinary, to be honest with you. I was just talking about having the flexibility with other benefits, depending on the particular area that a plan may be operating in. But certainly some things—like I said, dental; hearing aids is another one which there is a huge demand for—that would be really important to put in all benefit plans if it is at all possible.

Mr. LEVIN. Thank you.

Mr. TOY. We definitely appreciate the innovations around flexibility as well that have come out in the last few years. We—I think the way we see it is from a perspective of individualization and personalization of treatment and care for our population.

We look at our data within the platform all the time, and what we try to see is people as individuals, and to try to create the best outcomes for those individuals. And we are within that bid construct, within that plan construct right now. But what I think we believe we will see more and more is creating that individualized care is leading to individualized benefits, as well. So the more flexibility we have, the better off we will be.

Mr. LEVIN. Well, you have, as a graduate of U of M, 16—14 U of M seconds to finish my time. Thank you.

[Laughter.]

Ms. MORTENSEN. I would just add two additional things. I think it is great that there is increased flexibility and additional benefits, particularly benefits that address social determinants of health. But it would be important to make sure those are reflected in the updated quality metrics, so you can see if those investments are paying off.

But I would also suggest be careful of unintended consequences and make sure that these are not benefits that are just going to Medicare Advantage enrollees, and make sure that traditional fee-for-service Medicare beneficiaries are not left out of some of these comprehensive improvements.

Mr. LEVIN. Thank you very much.

Thank you, Mr. Chair.

Chairman ROSKAM. Mr. Smith.

Mr. SMITH OF NEBRASKA. Thank you, Mr. Chairman.

Thank you to our panel, as well. You have touched a lot on the Star Rating situation, and perhaps the star ratings give—or portray something that isn't necessarily a complete picture.

And a couple of weeks ago, we had a roundtable, a bipartisan gathering here. A constituent, Leslie Marsh, a CEO of a critical access hospital, Lexington Regional Hospital, brought to our attention the impact the Star Rating system is having on small, critical-access hospitals. And so she pointed out, as you might imagine, that many perform extremely well under the Star Ratings. Their

rural status can sometimes prevent them from actually qualifying under certain star ratings in and of themselves.

So just a few numbers here. You might be familiar with the North Carolina Rural Health Research Program that found that critical-access hospitals were less likely to receive a quality Star Rating than other types of rural hospitals. The study found critical-access hospitals comprise 90 percent of the 762 un-rated rural hospitals. And the same study concluded 43 percent of the not-rated rural hospitals were in the Midwest census region, which certainly includes my home state of Nebraska.

And as a result of not being rated, the critical-access hospitals show up under the hospital Star Rating's website as having zero stars. If consumers equate zero stars with poor-quality care, it is obvious how this could be a problem for many of the hospitals that actually provide superior care.

So, Ms. Klausner, in your written testimony, you describe the need for regional adjustment for Star Ratings. Can you talk a little bit about the data and research that could help us determine how to make the adjustments so that the Star Rating system would better account for the different operations at rural facilities, while certainly still holding hospitals to the same high standards as an urban facility?

Ms. KLAUSNER. I can talk for a minute about the need for regional adjustment certainly within the five counties that we operate in. Again, I reference Philadelphia, which is a very large, poor city, and the utilization in Philadelphia County is different than some of the outlying counties. The hospitals that are in Philadelphia, the University of Pennsylvania—Jefferson Medical Center—operate differently than some of the hospitals in our rural counties.

I will defer to Dr. Mortensen, though, on the regional differences in quality, because I think she might be a little more expert in that area.

Mr. SMITH OF NEBRASKA. Ms. Mortensen.

Ms. MORTENSEN. Unfortunately, I am not. So I am living in Miami-Dade County, where 65 percent of our beneficiaries are on Medicare Advantage plans. So we don't have any of the rural issues in Miami-Dade. So I don't know.

And I didn't realize that this was an issue, so that is a really important issue. It sort of flies in the face of some of the other issues we have seen, which are contracts like that getting bought up by four-star or five-star rankings, and then that star ranking tends to account for all those different plans across that contract purchase. But I don't have solutions for the specific issue you are talking about.

Mr. SMITH OF NEBRASKA. Okay. And anyone else wishing to comment?

Mr. Hoadley.

Mr. HOADLEY. Yes, I could make one comment. When I was on MedPAC, we developed a concept of a peer grouping approach. And so, you don't necessarily want to change the Star Ratings for whatever the demographic category is that may have poor performance, whether it is SES, whether it is rural, different kinds of things. Comparing for the purposes of payment and other things like that, hospitals, health plans—again, whichever category we are looking

at—that are within the same peer group on that particular criterion is a way to make sure that reward systems treat everybody fairly, but still identify if there is poor performance. It ensures that we are aware of it and that continues to have the incentives for those that might be performing more poorly to improve what they are doing.

So, it is a more of a peer group approach, as opposed to actually changing the ratings based on characteristics.

Mr. SMITH OF NEBRASKA. All right. Thank you very much.

Thank you, I yield back.

Chairman ROSKAM. Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman.

Thanks to all the witnesses for being here today. And, listening to your testimony, you paint a pretty nice picture of the Medicare Advantage program and the high quality of private insurance options that serve, I think, one in three seniors.

I want to just point out that it is a highly regulated market, and it does, in fact, deliver a product that consumers like. And thanks to the work that we have done in improving the program over the years, it is a very popular program with Members of Congress on both sides of the aisle. And I say that because I think it is important to contrast that with what is going on in the individual market.

You know, it seems that every turn this administration and the Majority are doing everything they can to whack the individual market, and you don't have to look any further than the farm bill that is going to be up this week, where they are promoting programs that bring back junk plans that work really well until you need to use them to cover your health care costs.

And it is causing problems. The cost in the individual market continues to soar. And I don't understand why we can't work together to provide the same quality of coverage in the individual market as we seem to want to do in the Medicare Advantage market, and make these plans both cover the needs of the consumers and do it at a cost that they can afford.

And I have got some questions for you on the MA program, and I hope that we can learn something that perhaps we can apply later on to the individual market.

So, Dr. Hoadley, I appreciate your suggestions on the improvements for the Plan Finder, and I think we should do everything we can to improve consumers' experience for seniors and make those plans easier to select. And one resource that you mentioned are the state health insurance assistance programs, the SHIP. But in the fiscal year 2019 budget, the President eliminated that program.

Could you tell me what kind of impact that might have on seniors?

Mr. HOADLEY. I think the SHIP programs represent a resource that is very important to a lot of seniors. While many people can go to an online Plan Finder, whether they do it themselves or whether they rely on children or grandchildren to help them do it, there is only so far that the Plan Finder, even if it is modernized, can go. For many people, what they really want is in-person, one-on-one kind of assistance that is only possible through something like the counselors that are provided in SHIP programs. There are

other resources to provide that kind of one-on-one help, in addition to SHIPs, but SHIPs have been an important resource to do that.

One thing I mentioned in my testimony was the potential for a web chat function that would allow a small version of that kind of individual counseling: I have this specific question; can you answer it for me? But that is not going to be the kind of in-depth help that somebody gets when they sit down, sometimes for two or three meetings, you know, maybe 30 minutes, an hour—

Mr. THOMPSON. So what happens to those seniors without this program?

Mr. HOADLEY. Without that program, they are going to rely on family members; they are going to try to rely on the Plan Finder. But they are going to end up probably, in some cases, making poor choices that will cost them money and fail to take advantage of a very valuable MA option in their area or determine that traditional Medicare might work better for them.

So it is those choices, if they make them the wrong way, that can not only cost money, but can put them in a lower-quality environment.

Mr. THOMPSON. Thank you.

And Mr. Toy, how can we ensure that a health plan's cost controls aren't hurting the patient? What steps do you take to ensure that those cost constraints are driven by clinical decisions, and not something else?

Mr. TOY. That is an excellent question. We are very, very outcome-oriented, so we would never want a decision we make from a utilization perspective, a cost perspective, to affect the outcome for the member. So we always very much are centric on the outcome. That is what we study in our data patterns and our statistics. That is how we apply our decision-making, as well, when we do plan design, when we do intervention design.

And so, while cost is a component, obviously, of any decision, it is not the primary way that we make these decisions. We always have member care, first and foremost.

Mr. THOMPSON. Thank you.

And Dr. Mortensen, what should we be doing to improve data availability, and how does that lead to better interoperability?

Ms. MORTENSEN. So, just recently, Seema Verma announced that the Medicare Advantage claims data would be released to researchers. So this is the first time—the data had been collected since 2012—that researchers would actually have access to these data. I think access to these data is really important because we as researchers can go through and identify some of the issues with the data, and the data can also be used to get to some of the more outcome-oriented metrics that I was suggesting before.

So, for example, you could look at an in-patient visit and see if it is what we call ambulatory-care-sensitive. So is that a visit in the hospital that should not have happened, because it could have been prevented with good outpatient care? So some of these patients should never show up in the hospital, the emergency department.

With access to these data now, which we have had for Medicaid, we can now do for managed care and Medicare. We can start to as-

sess whether or not enrollees are getting the access to care that they need.

Mr. THOMPSON. Thank you.

Chairman ROSKAM. Thank you.

Ms. Jenkins.

Ms. JENKINS. Thank you, Mr. Chairman, and thank you all for being here today.

Medicare Advantage has seen revisions and improvements over the past couple decades, from a renaming of the program back in 2003 to the most current updates in the Bipartisan Budget Act of 2018. As Congress continues to look for new ways to improve the Medicare Advantage program and health care for the American people as a whole, we really appreciate your expertise, experience, and feedback that you are sharing with us today.

In the 2017 Final Call Letter, CMS first implemented a temporary socio-economic-like adjustment called the “categorical adjustment index.” However, the adjustment seems to impact very few plans. In the 2019 Final Advance Notice and Call Letter, CMS stated that it remains committed to the goal of finding a long-term solution to the unique challenges of serving our most vulnerable populations.

There continues to be additional work in the research community on both identifying the impact of social risk factors on health outcomes and how to best address the impact on clinical quality measurement. Based on this, I have just a few questions that I would like to ask regarding adjustments to the current Star Rating measures for socio-economic status and geography.

Ms. Mortensen and Ms. Klausner, are there any measures in particular that should be risk-adjusted for socio-economic status?

Ms. KLAUSNER. Of the current measures, I think there are some questions. Like, for instance, I think there is a measure around risk of fall, and did your physician speak with you about your risk of fall. I think that could be expanded to ask additional questions around the current living situation that the beneficiary is living in. People who are living alone might have a different answer than somebody who is living with somebody else.

There are probably other measures that I don’t have off the top of my head that we could use to address those social factors, and I think that would be a terrific way to begin assessing whether some of the social works that we want to do and place would have an impact on the beneficiary outcomes.

You know, there is no questions around nutrition, to be perfectly honest with you. And if you don’t have food—and I am not even just talking about healthy food, I mean food on your table—that could be a significant factor in your health outcome.

So I think there are modifications that we should look to put in place that address those factors.

Ms. MORTENSEN. Yes, I agree with all the points that you made when you started, that it is troubling that the introduction of this adjustment had very little effect. So it was something like four percent of plans actually received improvements in quality when they started adjusting for socio-economic status and chronic conditions in their patient population.

I am going back to existing metrics. Which ones do I think that could address the socio-economic diversity could be the readmission rates. So there is a lot of research done suggesting that a readmission rate should be adjusted throughout the Medicare program to address these, you know, chronic conditions and where you live, what hospital you are going to, and to where are you being discharged once you leave the hospital. I think, going along with her point, something we should think about are these additional measures that we use to replace some of the existing quality measures could be more focused on looking at measures and metrics that could adjust for that.

And so one suggested metric could be what Humana uses in a lot of their communities—their healthy days metrics, or one that MedPAC is investigating, which is called a healthy days at home metric, where you can use technology to scan through the claims to see how many days in the year where the patient was not in the hospital, was not receiving home care, and so you could use metrics like that that could try to assess more socio-demographic factors.

Ms. JENKINS. Okay, thank you.

And finally, Mr. Toy, how can the current Star Rating measures change to focus on and incentivize better health outcomes?

Mr. TOY. So I think that when we look at the Star Ratings, often times they are not directly connected to the outcomes, like you say. They are a proxy towards them, but they are not ultimately measuring the final step with our members. So they are, however, really important, obviously, for us to comply with in the short-term.

I think one thing we can do, from our perspective, is really analyze the data. Like a lot of us at the table, certainly we at Clover have statistical data that actually shows correlations between lots of these things. We can detect, for example, indications of homelessness or having a proclivity towards homelessness from the call data, when people call into our call center, the kind of words they use, and those can be very strong signals that we can use to inform the Star Ratings, as well, to show how we are taking care of those populations.

Ms. JENKINS. Thank you. I yield back.

Chairman ROSKAM. Mr. Kind.

Mr. KIND. Thank you, Mr. Chairman.

And I want to thank the witnesses for your excellent testimony here today, again giving us some hope about what is happening in the health care system.

But Ms. Mortensen, let me start with you and just pick up where you left off with Mr. Thompson, and that was the acknowledgment of opening up the MA claims data to outside researchers.

You know, this started back with the American Recovery Act during the Great Recession, where we threw a lot of money in the HIT investment, or EMR investment. And I always felt it was important to do that so we can start collecting the data, as far as what works, what doesn't work, and then drive that back down into the hands of the doctors and the patients alike, so they can make good decisions with it.

So how significant—and I think the missing piece was the MA claims data being shared to outside—how significant is it, and

what do you think is going to evolve from that? What do you think will happen, making that available to researchers now?

Ms. MORTENSEN. First, I want to speak to your point about the Reinvestment Act and the HITECH Act, specifically; that put a lot of money into electronic medical records. And that is a sort of precautionary tale of we have to be really careful of unintended consequences. So almost every hospital now has an electronic health record system, but none of our records are interoperable and actually speak to one another. You see this within buildings, within health systems.

You know, I think it was Trinity Health announced—

Mr. KIND. Unless you are using Epic, which has 50 percent market share, and—

Ms. MORTENSEN. Exactly.

Mr. KIND. Of course, then they are all interoperable.

Ms. MORTENSEN. Trinity Health announced last week they are going to now use Epic across all of their sites, which kind of already assumed that they were interoperable. So it is careful (sic) to think about what—as we prescribe things with policy, not to over-prescribe and make sure that things go well.

So, just to be clear, although data are now available to researchers on Medicare Advantage, there are a lot of hoops to jump through in order to get those data. And so the data that are available now are through 2015, and we are in 2018. So what we can go back and say retrospectively, in 2015, these were some good things and bad things that were happening. But we are nowhere near a real-time adoption of data, which would be incredibly helpful for researchers and—

Mr. KIND. I will certainly encourage you and others that, if there are some hurdles or unnecessary impediments to getting this out, that you bring it to our attention so we can work with you and work with CMS to see what we can do to facilitate.

Ms. MORTENSEN. Absolutely. Thank you, I appreciate that.

So in general, I think that as you get academics with their hands on the research, they are able to come here and inform you, “Here is what we can do.” So, for example, that ambulatory care sensitive data analysis that I do in my own work in managed care, I can use that to now inform and say, “Hey, this is a great outcomes measure.”

So although we did not see in Florida, for example, ambulatory care visits decrease, we saw a slow in the growth. So we can look for trends like that that are encouraging. So access to the data is tremendously important for researchers, but also to help inform policy-makers, as well.

So thank you.

Mr. KIND. Thank you.

Mr. Hoadley, there was much made of the fact that under the Affordable Care Act, as part of the pay-for, that there was going to be some significant reductions in the MA plan reimbursement rates. As a consequence of that now, was there any adverse impact on the enrollment of the MA plans and the services that were being offered, on the quality outcomes that we were asking of these plans, in light of those cut-backs?

Mr. HOADLEY. Yes, certainly there was no drop off in enrollment in the MA plans, and I think some of the projections thought there might be. People continued to seem to want to join those plans, and the numbers have continued to increase.

I think some of the other questions are still harder to answer, and part of it is the absence of the ability to look at encounter data. If we are trying to understand such things as the way a Medicare managed plan manages, for example, post-acute care use, we need to know are they sending people to different sites for post-acute care than is going on in traditional Medicare? Are they managing to make less use of post-acute care? And then what are the outcomes?

We really need to be able to look at encounter data to be able to address questions like that and really get us to the answers of whether the quality of care received is affected adversely or positively—

Mr. KIND. Let me ask you in the post-acute-care world, because Chairman Brady and I have been trying to move a discussion forward on the reforms that we feel are needed in post-acute care. I think it was one of the things we missed under the ACA Act, quite frankly.

Is there a lot of opportunity for reforming that for better outcomes and ultimately a better price?

Mr. HOADLEY. There certainly are. While I was on MedPAC, we took a fairly extensive look at the broad issue of how to pay for post-acute care, and have a series of recommendations on revising the payment systems. Medicare Advantage plans, to some degree, are able to do some of those things today.

But what we really need is better information on what are they doing. Have they taken steps that have had positive effects? Are they trying to make sure that the differential payment in different sites, whether it is a nursing home, or a home health, or a rehab hospital, yields the same results when the payment systems are different and the incentives to use those different services vary, that is the thing that is keeping us from getting the improvements we would like to see.

Mr. KIND. Yes, thank you. Thank you, Mr. Chairman.

Chairman ROSKAM. Mr. Marchant.

Mr. MARCHANT. Thank you, Mr. Chairman. As I travel around my district and visit with seniors and almost every group that I have, they come up to me after the meeting and one of the most frequent comments is, "Please don't do anything to take away my Medicare Advantage."

So Medicare Advantage is a very vital part—I represent a largely suburban, corporate-oriented district that many of them are coming off of a corporate plan, they are coming off of a very high level of insurance—and with a lot of trepidation. They hit that 65 mark and have to begin to make those decisions, and I had to make that decision last year, and I will have to say that as I sifted through, it seemed like hundreds of letters that I got, trying to keep me informed, there seemed to be very little substantive information in those letters from Medicare are the private vendors that were trying to get me to sign up for them about Medicare Advantage.

So in my district, 32 percent of the people that are on Medicare are on Medicare Advantage. So I would be interested, Dr. Hoadley, I would like to agree with you that education is probably the number-one thing that needs to be improved in that system so that people can blend their co-insurances, their supplemental, and blend the whole system together.

Can you name some kind of a concrete program or improvement in that area that is taking place as we speak?

Mr. HOADLEY. So I think you are absolutely right, that education is critical, and there are a lot of tools out there to try to help people. And I think the Plan Finder that I have talked about in my testimony is something that has been a valuable tool for more than a decade to help people understand.

But it is an online tool. 10 or 15 years ago we were concerned that a lot of seniors really weren't computer-savvy, weren't going online to do choices. That is gradually changing, for the new generations. We have a Plan Finder that really represents technology of 10 or 15 years ago, and it has not been modernized and updated to reflect both the use of the tool on different platforms. If you try to use it on a tablet or on a phone, it may not appear very well; it may not allow you to do things. But even if you go to a laptop or a desktop computer, you are still struggling to try to get it to work and get it to provide the information.

And one of the important ways that fails is trying to compare what you get in an MA plan versus what you get in traditional Medicare, and put together all of the elements in your coverage—the MA plan, combined with your supplemental insurance, whether it is from a former employer or from a Medigap plan.

And what you really want is a good, out-of-pocket cost estimate of what are my total costs going to look like, as well as what providers all have access to. And right now, the tool just isn't doing that very well.

And it is not going to be that hard to fix it. You know, we know how to do those kind of things better. But we need some investment of time and resources and reach out to the community, to the stakeholders, to the beneficiaries, the plans, and the rest of the community to figure out the best way to do it.

Mr. MARCHANT. I have got one more question. In 2019 Parts C and D final—in the final rule, CMS finalized its proposal to eliminate the mandatory enrollment requirement previously proposed by the Obama Administration and replaced it with a policy that requires plans to reject providers and suppliers who are included on a preclusion list.

Ms. Klausner, can you discuss some of the challenges, plans we are having—some of the challenges the plans were having with implementation of the previous mandatory requirements?

Ms. KLAUSNER. Yes. First, we were happy that they delayed that rule and that they have since changed it. We are still awaiting policy guidance on how to implement that. But as a plan to rely on two different exclusion lists for providers would be operationally challenging.

Historically, we have relied on one, so the possibility that we would have two for different types of providers would have been

quite challenging. So we are looking forward to the guidance from CMS on how to implement the new change.

Chairman ROSKAM. Ms. Sewell.

Ms. SEWELL. Well, first I want to thank the witnesses for being here today.

Last year, I told the Committee a story about one of my constituents from Selma, Alabama, a Miss Eva. Like many of our rural constituents, Miss Eva called my congressional office to see if we could help find her a ride to the pharmacy so that she could get her insulin, or to the doctor so that she could get her routine check-in for her diabetes management.

Miss Eva told us that she goes to the emergency room in an ambulance several times a year for issues that could have been addressed earlier in a primary care setting if she had access to proper transportation. A dual-eligible diabetic in her eighties, Miss Eva found that the state's non-emergency medical transportation benefit through Medicaid was unreliable. Thus she would call us for transportation needs.

Miss Eva's story is one we could tell 100 times over in this Committee. Whether it is an inability to afford a copay or transportation, millions of Americans across this country forgo primary health care visits and don't adhere to medication regimens because of financial constraints.

I know that when I visit emergency departments across my district and talk to providers, it becomes increasingly clear that social determinants of health such as transportation barriers or poor housing are driving the lion's share of costs in the Medicare program. We may not be able to prevent all of the chronic conditions, but it seems to me that we could do a better job of trying to control some of those costs by just being smart about it.

One of the things that I think would be of great help is if we look at the models in which we have medical Uber, or something like that with ride shares, where we can reimburse providers who have this kind of ride share. I know it is more difficult in rural parts of our nation, but I do think that we need to start thinking outside the box when it comes to social determinants such as transportation.

And, in fact, I really am passionate about this, and Mr. Meehan and I had a bill that would allow for just that kind of transportation needs that Medicaid offered for non-emergency transportation we now have in Medicare Advantage. It was passed in the most recent February bill, and that was great. But I think that we have to do more for that.

And so I guess my first question is to you, Ms. Klausner. I know that you have been in this industry for a very long time, and transportation is only one of those barriers. And so I was wondering if you could speak to other social determinants that affect the outcomes. And can we in Congress think outside the box about how we can address some of those determinants so that we have better outcomes for our MA patients?

Ms. KLAUSNER. Well, we are also very passionate about the same issues as you are at Independence. We talked about transportation, and so we applaud the flexibility that we are able to hopefully offer transportation benefits.

At Independence, we are also talking with some of our providers who are also interested in the same outcomes. So we have recently talked to a provider group that will be coming into Philadelphia to address low-income seniors. And they, as part of their provider group, offer transportation. So we are really excited about that, that initiative.

I also mentioned food. So we talk about out of the box. I think food is probably one of the most critical factors to people's health care.

Ms. SEWELL. Absolutely.

Ms. KLAUSNER. And again, not just healthy food, I just mean food, right?

Ms. SEWELL. Food. Agreed.

Ms. KLAUSNER. Agreed.

Ms. SEWELL. You know, the other issue that I found really important, I most recently—over the weekend—went to the inaugural enrollment of All of Us program for University of Alabama Birmingham, as one of the providers for precision medicine.

I really wanted to hear from you, Ms. Mortensen, about big data and getting data analysis such that we can drive better, more appropriate treatment that—going away from sort of the average patient to this one-size-fits-all to something much more specific and much more precision—your thoughts about that, and also how we in Congress could do a better job of helping get that data more real-time, because you said that it was 2015 data.

Ms. MORTENSEN. So thank you for the opportunity to speak specifically on social determinants of health, because they really do matter.

So one exciting program already underway within CMS in both their Medicaid and Medicare beneficiaries is called accountable health communities model. And so what it is, from a data perspective—we love this, because it is a randomized control trial.

And so what you have is—now it is down to two tracks, where—these are alignment tracks, essentially, so that the most comprehensive track is aligning Medicare and Medicaid beneficiaries within an organization, what is called a bridge organization, that says if your food—if you need food, here is a food pantry that knows you are coming, and they will be ready to serve you. If you need transportation, we are connecting you with transportation. If there is something in your home that is unsafe, we have somebody who will come and help make your home safe.

So this is partway through, but randomized control trial data evidence, this is going to show that investing in social determinants of health prevents the downstream expense of use of health care. So those metrics will be really, really important, and I think will make all of your jobs easier on making these kinds of—

Ms. SEWELL. Thank you very much.

Chairman ROSKAM. Mrs. Black.

Mrs. BLACK. Thank you, Mr. Chairman, for holding this informative hearing.

And as a registered nurse for over 45 years, I have seen firsthand the critical importance of value-based services that they play in today's health care system. And we all know that if Medicare is to provide a real benefit to our seniors while ensuring real effi-

ciency for our taxpayers, it must embrace the advances in technology that are already taking place around the health care sector.

By focusing on the high value services essential to our patients, especially those suffering from chronic conditions, I believe that we will begin to move away from the fee-for-service care program and into a system that rewards quality, which we are already seeing.

I was very excited to see two policies that I have long championed into Medicare Advantage signed into law by President Trump earlier this year. The first one is Increasing Telehealth Access in Medicare Act, which I cosponsored with Mr. Thompson, and it gives plans a new flexibility to provide telemedicine benefits in Medicare Advantage, which I think is going to really move us along. And then the V-BID for Better Health Care Act (sic), which I sponsored with Mr. Blumenauer, that will expand the value-based insurance design model nationwide, helping seniors with chronic conditions to better afford their medications.

So the MA plans that are increasingly utilizing technology to manage the costs and improve care of their high-cost beneficiaries, such as those in long-term care facilities is a concern of mine. More recently, innovative companies are partnering with Medicare Advantage plans to address this issue, specifically using telehealth to treat in nursing homes in place, instead of transferring a patient to an emergency room. We know this not only is more efficient, but it is more efficient for the patient, not to have to move them out of their facility and move them, via ambulance, into a hospital setting.

So using innovative telehealth technology like video conferencing to connect patients with more remote emergency physicians, we can reduce these expenses to hospital visits and save the patient that inconvenience, as well.

Mr. Toy and Ms. Klausner, you both touched on how the plans have more flexibility to offer telemedicine services to their members, which will help to increase access to care for those individuals right in their homes, which is so convenient.

Mr. Toy, can you address how else can we support the MA plans in integrating that technology in a way that benefits our beneficiaries, the plans, and the taxpayers?

Mr. TOY. Absolutely. And we are a big supporter of at-home care, for all the reasons that you said just now. So we have a plan focused specifically on treating folks at home, especially for chronic conditions.

We also, in those exact same cases, identify those populations ahead of time, and then provide them with equipment at home, such as telecommunications equipment. We provide actually a smart speaker that you can push a button and immediately get in contact with somebody if you need help at our call center, as well as being able to do your medical appointments.

We also have social work available through a partnership, where you can actually get social work, if you need that as well, at home.

So all those are, I think, really important things that we are able to provide.

Mrs. BLACK. Excellent. Ms. Klausner, in our rural areas, it is often challenging for plans to build those robust networks to meet the CMS's "time and distance" standards, particularly for certain

specialties. How do you plan on using this new flexibility? And do you think that CMS should consider adjusting the network adequacy standards to take telehealth into account, particularly in these rural areas?

Ms. KLAUSNER. I think the new requirements or new legislation around telemedicine will be hugely helpful for rural areas.

I mentioned our new partnership with Comcast. I have to say one of the early prototypes that I saw was really fascinating, because it didn't only connect the patient with their physician, but also the caregiver. So we have beneficiaries who have children and grandchildren who live very far away. And being able to connect those caregivers to the doctors, to the patient sort of collaboratively is really exciting, and I look forward to seeing what we do with Comcast in that space.

I think the network requirements are there for a reason because they want to make sure that people have access. But I do appreciate Mr. Toy's position about certain areas where it is more difficult to provide those services.

I think we do need to look at regional differences in how health care is delivered, and how people utilize health care, depending if it is an urban or a rural environment. So I do encourage this Committee and CMS to look at the changes and look at specifically how health care is delivered in different parts of the country.

Mrs. BLACK. Thank you, Mr. Chairman. I yield back.

Chairman ROSKAM. Ms. Chu.

Ms. CHU. Dr. Hoadley, thank you for sharing the beneficiary perspective, as we discuss ways to improve the Medicare Advantage program.

One thing I often hear from my constituents is how burdensome the cost of prescription drugs are for them. The costs continue to rise. A study from AARP noted that 97 percent of widely-used brand-name drugs have seen a price increase exceeding inflation in 2015. And already the cost of Medicare is significant, as 19 percent of the total Medicare budget is spent on prescription drugs.

But for patients, all they see is the price at the pharmacy counter, and it keeps going up. So when they are selecting a plan, they want to know what option will result in the least out-of-pocket cost at the end of the day.

Dr. Hoadley, you described the problems with the Medicare Plan Finder. But what can we do to make sure that beneficiaries can anticipate their out-of-pocket costs, particularly as it pertains to prescription drugs? Are there any steps we could take to improve the Plan Finder's ability to show patients what they are going to be expected to pay in the end?

Mr. HOADLEY. So the Plan Finder does have the functionality where you put in the names of the different drugs you are taking, and you determine, for the particular plans you are looking at, whether those drugs are on the plan's formulary. This tells you whether you are going to be paying completely out of pocket, or whether you are going to be paying only a co-pay or a co-insurance for that drug—and tries to estimate the potential cost sharing for that drug.

Now, there are complexities that need to get improved to make that work better. For example, in many cases, the price is going to

vary according to which pharmacy you are using. So if you are committed to one pharmacy that is your go-to place, you can designate that pharmacy on the Plan Finder and you will get prices that are based on using that pharmacy. But if you are a person who is willing to switch to a different pharmacy in order to save money, that is hard to figure out.

I actually went through it for myself and for our family, trying to figure out whether there were opportunities to pick a different pharmacy and to end up with a better cost. I eventually figured out that that was the case. But even for somebody who has studied the Medicare Part D program for as long as it has been around, I had trouble figuring out how to do that.

There are also issues sometimes when people see a particular price on the Plan Finder when they are shopping for a plan during the open enrollment season—say in November—and then they go and try to pick up a drug in February, once they are actually enrolled in that plan, the price ends up being different. Now, there are a lot of reasons that happens—the manufacturer may have raised the price—but these discrepancies are very frustrating to people.

And it would be really useful to have a better sense of why those happen. Then we should figure out if there was some way to make sure that prices can be locked in, so you are not going to see changes from the time you shop for a plan to the time you actually go and buy the drugs.

Ms. CHU. Thank you for that.

Mr. Toy, Ms. Klausner, as a psychologist by training, I am particularly interested in the way that Medicare Advantage can assist in the integration of mental health services in the health care space. We know that when someone is depressed or lonely they can take longer to heal. And in fact, studies from numerous universities have demonstrated that loneliness has measurable negative impacts on patient health.

That is why I am proud that Care More, a Medicare Advantage plan that serves my district, was the first in the U.S. to have a dedicated integrated program designed to combat loneliness for its Medicare population called the Togetherness Program.

And one of their patients, whom I shall call Susan, was in her eighties, was homebound, and experienced physical pain when doing light housework. She used a walker to get around and stated that this was a source of embarrassment for her, so she used that to avoid social interactions.

So as part of the Togetherness Program, an employee with Care More called her at least once a week to check in with her, have a conversation, and encourage Susan to go outside to have exercise, even a short walk around the block. And, as a result, Susan is now getting out and regularly attends social events.

So I would like to ask you, have you identified any barriers in the Medicare Advantage program that prevents plans from addressing mental health needs like loneliness as a part of a more holistic approach?

Mr. TOY. I would say it was a little harder in the past. But with the new flexibility that we talk about, where we can add these benefits to our plans, we are able to do things like exactly what you

said, offer community benefits to actually make our members feel like a part of the community, have social interaction.

We also have our nurse practitioners who visit them in their home and can identify when they might need a little bit of extra help on the social side, if they are being reclusive. And so definitely an area we are focused on. And I think, in the future, we will be able to invest a lot more in that area.

Ms. KLAUSNER. And I would just say that I have read about Care More's model, and we think it should be a model for the entire country. That is really important and very successful.

We are looking forward, again, to the flexibility that CMS is now granting us to address issues like loneliness as another social determinant that we feel very strongly about. And especially around mental health. So it is a focus of our plan. And again, the flexibility that we now have will allow us to do more in that space.

Chairman ROSKAM. Thank you.

Mr. Paulsen.

Mr. PAULSEN. Thank you, Mr. Chairman, also for holding the hearing today.

There is pretty strong recognition that Medicare Advantage is improving patients' health, based on the testimony we are hearing from you, based on the questions that are coming from all of us. It is using best practices in care delivery, it is the robust data analytics, it is proven, value-based care and the care management models that are available through MA.

And when you have got one out of every three Medicare beneficiaries that are utilizing Medicare Advantage, that tells you something. I represent a community certainly where I hear on a very regular basis from seniors in my community, "Please make sure we continue the Medicare Advantage program." That is a consistent message.

And whatever we can do to help encourage more enrollment in a program that could lead to better health outcomes for our seniors and lowering health care costs is the direction we need to go. And this has been very helpful today.

I know that the different health plans in particular have engaged in the marketing efforts that Representative Marchant had mentioned to help educate seniors about their options when you have got fee-for-service plans, Medicare Advantage, and then Part D drug benefit plans.

I know CMS also has used a marketing or a Part D program education effort to enhance their enrollees to 42 million-plus by running an extensive national education campaign, you know, with mailings and flyers and television, et cetera, and advertising.

I am just curious, Mr. Toy and Ms. Klausner, I will start with you. Do you think that CMS could increase enrollment in MA programs by conducting a similar campaign? And, if not, do you believe there is a better or more effective outreach solution to increase—or more than one out of every three?

Ms. KLAUSNER. So I think that paying attention to collaboration between CMS and the plans to increase education would be tremendous. I think CMS could focus on certain areas where Medicare Advantage enrollment penetration is lower than in other areas.

So, for instance, in Philadelphia we have 40 percent enrollment penetration in Medicare Advantage, but there are certain pockets in Philadelphia where there is 10 percent penetration in Medicare Advantage. And I think it would be great if CMS and the plans could work together to figure out why is the penetration lower in certain pockets, in certain areas of the country where it is not at the 40 percent. Sometimes it is the number of plans that are available.

But I do think you are correct in that it is also about education and not being afraid of managed care, which is a little bit of a hold-over from, you know, history. But I think that would be great, to collaborate with CMS on that, from the plan's perspective.

Mr. PAULSEN. Mr. Toy.

Mr. TOY. I completely agree that we could do more with CMS. And I think that part of this is that, as we have been discussing today, there is a lot of innovation and flexibility that we can get through Medicare Advantage that traditionally the enrollees would not think of as coming from a health insurance plan. Right?

So because we don't look like health insurance plans any more, the more of the traditional marketing methods to try to jam us into that box and—when really, we are saying, hey, we are really going to look after you as a total life care experience.

And that is very hard to get across, when you are just saying, hey, no, how does this compare to just traditional fee-for-service? How do the copays compare? How do the premiums compare? We would like to be compared on different axes and marketed on those differentiators, as well.

Mr. PAULSEN. So, Mr. Hoadley, you talked a lot about the need to modernize the website, make it more user friendly, 30 tabs opening up. I can only imagine how confusing that is for folks trying to navigate all that. My understanding is the Medicare Plan Finder is updated maybe once a quarter on the website. Other websites are updated on a daily basis, right? We know that.

But maybe, Mr. Hoadley, you can comment a little bit more along those lines about how often CMS should be updating its website, as well as are you aware of any specific audiences, be they rural or race or ethnic or homebound seniors that also need sufficient education, where we need to penetrate that market?

Mr. HOADLEY. Well, I think you are raising good points. We need to have a tool or a series of tools. The online Plan Finder may work for some audiences; for others it may be the in-person assistance that can help them understand the differences for different choices.

And I think there are a couple of things that would help. I talked a little bit in my testimony about the potential for information overload. People see so many disparate choices, and they just say, "I just don't want to deal with it, I'm just not going to make it, I will stay wherever I am." Now, maybe they are in an MA plan, maybe they are in traditional Medicare, but there may be a better option out there for them. And if they are in a situation where they just shut down and stop looking, that is not helpful.

So I think anything we can do to make the information clearer and cleaner, with less of the sort of distractions of small differences, would be helpful.

Another thing that I think could potentially help is there was discussion at the beginning about the role of supplemental insurance for traditional Medicare, the Medigap plans. When people are in a Medigap plan with traditional Medicare, they may go off and try Medicare Advantage. Then if they want to come back to traditional Medicare, they may not be able to get their Medigap plan back, or they may have to pay more for it. And to the extent that they understand that, that may actually deter them from trying out a Medicare Advantage plan.

So, while in a way it seems almost backwards to help to provide more portability of Medigap coverage, it may actually help people explore the options of Medicare Advantage more readily. And so I think a policy change where we can make sure that you can reacquire your Medigap plan after you have spent a time in Medicare Advantage would be helpful. Right now you can do it if you stay just a very short time, like “I didn’t really mean to go there, I want to get back.” But maybe you are in it for two or three years, and then the plan in your area changes, and you are not so interested any more, but now you can’t go into Medigap. And if you think about that in the front, maybe you never try that plan in the first place.

Chairman ROSKAM. Thank you.

Mr. Kelly.

Mr. KELLY. Thank you, Mr. Chairman. Thanks for holding the hearing. And thank you all for being here, because I think on both sides of the aisle we are very, very concerned about this. Any program that has a cost of over \$700 billion a year should be important to all of us.

One of the main problems I think in Medicare Advantage is the benchmark cap, which was created under the Affordable Care Act. And many beneficiaries in my district, which—by the way, over 350,000 people participate in Medicare—are impacted by a misguided policy, and do not receive the full benefits of being in a high-quality plan. Now, Mr. Kind and I have been working on a bill to eliminate the benchmark cap. And I think, Mr. Chairman, we will continue to work on that.

Another issue that I have been working on is the way CMS calculates Medicare Advantage rates. Currently, these rates include spending for beneficiaries with both Part A and Part B, as well as spending for folks with Part A only. This is comparing apples to oranges. And for seniors in the district I represent, they are getting short-changed.

So, Ms. Klausner, do you agree that CMS should be calculating rates based only on people who are eligible for Medicare Advantage? And how would this affect the beneficiaries?

Ms. KLAUSNER. I think we support rates being reflective of people who have Part A and Part B. I think what you are referring to is people who have Part A only.

Mr. KELLY. Right.

Ms. KLAUSNER. I think we are seeing a change in the way that people access their Medicare when they retire. We are seeing people retire later, so they might not be picking up Part B. And I think people who have just Part A only and may have employer

coverage on the B side, having two plans, are utilizing services differently. So we encourage rate-setting at a A and B level.

Mr. KELLY. Yes, I can tell you when we do telephone town halls, and when it comes down to Medicare and we try to get this out, I just sit back and I listen to people for an hour-and-a-half on how confusing it is for them to—which direction they should be going in.

So I just think, you know, at some point—we keep thinking if we just keep throwing more money at these things they will get better.

So I think one of the things that we have been discussing are ways to improve the Medicare Plan Finder. I know in my life—I am an automobile dealer—in a lot of the things that we do here I compare to warranty work. And there is no one size fits all.

And I think that too often we tend to group everybody in there and say, “Well, no, this is the way it is going to work,” and say, “Wait a minute, a person owning a car in the Northeast certainly has different conditions on that vehicle than somebody in the Southwest.” Same car, two different environments. The same thing it is with people.

So when you go to the Plan Finder, there are so many people in the private sector that right now do it well, and the reason they do it well is if they don’t do it well they go out of business. The government’s answer to doing something poorly is to put more money into it from hard-working American taxpayers and say, “Well, we are spending more money, so it must be getting better.”

I guess my question is so why don’t we just abandon something that is so new to the government? Again, I don’t believe the government should be involved in getting this information out, because they do such a lousy job with it. And I guess if it is not your money, you can spend it any way you want. But when it is your money, you have to be more careful.

Your opinions. I mean could this not be handled better, as—for navigating through the—people through these very difficult decisions?

Anybody? Because you all work on it, and I would like to get your input on that.

Mr. HOADLEY. So, in my view, the advantage of having the government operate the tool like the Plan Finder is you make sure that it is an unbiased tool that doesn’t tilt in any direction. My concern is that if different private vendors were to operate those kinds of tools, they may not be operated by an organization that has a particular interest in where people land. And so I think keeping it as an unbiased tool is the real advantage of having the government operate it.

Mr. KELLY. Okay. Well, let me ask you again, going back to my life, I couldn’t imagine having howtobuyacar.gov telling people where they should go to buy their car. But I do think in the private sector—again, I am going to what you all do every day. You know the pluses and the minuses, you know how difficult it is for people to navigate these things. I would stay as far away from the government as I could. An outfit that is \$20 trillion in the red is going to tell me how to buy my health insurance or what is in the best interest?

I mean surely there is a better way to do this, and we see it in the private sector every day. We have people that know how to do this. So while there may be a bias, and you may be right, but I would say, depending on how you calculate who the money goes to in the end is probably more logical.

So, I mean, Ms. Klausner, how do you feel about this? And the rest of you, if you can just weigh in, we are running out of time, but I just know there is a lot better ways to do these things than to keep using taxpayer money.

Ms. KLAUSNER. I actually think, to the point I made earlier, that better collaboration between the health plans and CMS—I think the government position and the independence that the government can provide is important for beneficiaries.

I think the health plans could educate CMS on what they are seeing in particular markets. I think different approaches for different markets would be important. But I think the main thing that I want to emphasize is the continued collaboration between CMS and health plans to serve beneficiaries.

Mr. KELLY. Okay. Mr. Toy, you were going to—

Mr. TOY. I was going to very quickly say that one thing to—that you may think about is that when I took a lot of start-ups that are looking in this area, where innovation can come, Medicare is not on the top of their minds, just because of the age differences, perhaps. And so, having some incentives for innovation from that area might be something you could consider.

Mr. KELLY. Ms. Mortensen, anything?

Ms. MORTENSEN. Sure. So I would just say right now we have one comprehensive source of perhaps difficult-to-comprehend information. I think if we left this to private sector or non-governmental organizations, you would then have four or five or six different organizations offering unbiased information that would be—you know, going back to measurement cacophony—even more information that would probably be even more difficult to process.

Mr. KELLY. Okay, thank you. I yield back.

Chairman ROSKAM. Thank you. Well, the herd is thinning, but the faithful are still here. So thank you all for your testimony. Let me kind of—Chairman's prerogative—let me just put together some of the themes that I have heard.

Mr. Toy, you talked about intervention and using the data as a tool. Can you sort of thread together these other themes of social determinants, and how it is that you at Clover use that information, if you do, to intervene and get better outcomes? How does that work?

Mr. TOY. Yes, absolutely. So the way to think about it is we sort of have generating insights. And from our insights we then activate interventions, actually improve outcomes.

Chairman ROSKAM. Okay. Translate that for me. What does that mean?

Mr. TOY. So what that means is a lot of companies right now, when we are looking at data to actually see something interesting that is happening out there, are only looking at one stream of, say, clinical information, like looking at just your body and your health.

Chairman ROSKAM. Okay.

Mr. TOY. Or they are looking at just, say, financial. As payers, we often look at just claims data. And we are like, well, what do we see in the claims?

Chairman ROSKAM. Are you getting other data? Is this like consumer data that is laying on top of this and, like, all kinds of things?

Mr. TOY. So we can. So this is the area of the new frontier now. Traditionally, only these, like, claims data, or just maybe—maybe clinical data from the EMR is looked at.

Now we can also look at social data, we can look at these dynamics that show signals towards maybe someone is homeless, or maybe someone is not eating well. This data was not visible before in just claims data. We wouldn't know that—

Chairman ROSKAM. Right.

Mr. TOY [continuing]. From just your claims information. By blending all these together, this is now the time when we are able to actually make these new, get insights and say, well, you know what? Maybe this person is using a lot of care in this area because they are not eating well. And—

Chairman ROSKAM. So this is all—just to—I want to open the aperture up a little bit wider—

Mr. TOY. Yes.

Chairman ROSKAM [continuing]. Just so that I am understanding. I am trying to restate what you are saying to me.

Mr. TOY. Yes.

Chairman ROSKAM. Let me see if I am tracking. So you are saying there is new information that is available. And the new information is beyond claims data, and it is wider medical data.

So here is—is that right?

Mr. TOY. It is wider medical data, and the social data on top of that, as well. So—

Chairman ROSKAM. Where is the social data coming from?

Mr. TOY. So the social data, right now, because we are just being very careful how we look at this—

Chairman ROSKAM. I get it.

Mr. TOY [continuing]. Is coming from sort of signals that we would get, for example, from notes, that—something that they would maybe mention to their provider, the provider would write and say, “Well, this person has mentioned that they have difficulty finding housing,” right? And then we will say, okay, that is an important data point, we can extract that from the clinical notes.

Going forward, I think we will start to see more and more use—of course, with the patient's permission—of other social signals, like maybe their online social network, and things like that, that we are only just starting to scratch the surface—

Chairman ROSKAM. That is pretty interesting. So, I mean, and not being a data expert at all, but my sense is that there will be trends and patterns that are surprising, maybe even based on consumer habits, that—

Mr. TOY. Yes.

Chairman ROSKAM [continuing]. That begin. And so that is sort of where it is okay. Okay, that is helpful, thank you.

Ms. Mortensen, when you were talking about the tension between—when I practiced law, there were substantive and proce-

dural due process. Mr. Levin can relate to this. And what you were saying is, look, there is a lot of process that we are chasing around right now, and we are not really evaluating the substance. Is that a fair characterization?

Ms. MORTENSEN. Yes, that is right. So largely because these process measures are easy to measure—

Chairman ROSKAM. Right.

Ms. MORTENSEN [continuing]. But they are also important to measure. Did you do this to the patient?

Chairman ROSKAM. It is check-the-box stuff.

Ms. MORTENSEN. Did they get a flu shot, mammogram, colorectal screening, et cetera?

Chairman ROSKAM. Okay. So, shift it. If you were going to redesign, you know, and you had just a clean palette, what would you shed and what would you embrace, in terms of evaluation, and stipulate that people are willing—you know, providers are willing and plans are willing to be evaluated, but they want the evaluations to be rational and to measure things that really matter? What would you propose that the ideal would be?

Ms. MORTENSEN. So the ratings shift each year, right? So as they top out, a lot of ratings are pulled out and additional ratings are put in. And you will see some ratings are in for a year and out for a year. So there already is movement.

So one thing is it might be nice for the plans—

Chairman ROSKAM. Okay, just to restate that, just so I am understanding it, what you are saying is if everybody is meeting the ratings, then they are kind of like not measuring anything—

Ms. MORTENSEN. Correct.

Chairman ROSKAM [continuing]. Any more?

Ms. MORTENSEN. So then a new rating, a new largely process measure will come in, although some years process measures would be taken out, and then maybe the next year put back in again. And the plans—

Chairman ROSKAM. Just to press the point a little bit, does that feel like the goal posts are moving?

Ms. MORTENSEN. So in Medicare Advantage Star Ratings, the goal posts are always moving.

Chairman ROSKAM. Okay.

Ms. MORTENSEN. And the plans don't know the goal posts beforehand, and they are told maybe midway through what measures are going to be looked at, and what is a three-star, what is a three-and-a-half-star, what is a four-star.

Chairman ROSKAM. I get it.

Ms. MORTENSEN. So none of these guys know, going in, what is going to be measured, and what the cut-off is going to be.

Chairman ROSKAM. A lot of—

Ms. MORTENSEN. Like I can tell my students an A is a 91 and above, right?

Chairman ROSKAM. Right.

Ms. MORTENSEN. They don't know what is a 3 and what is a 4.

Chairman ROSKAM. So a lot of pop quizzes here.

Ms. MORTENSEN. Exactly, right.

Chairman ROSKAM. Okay. So then go back. I interrupted you. You were going to say what is the process measurements that are de minimi and are not adding much value, and what is your term of art? I forget it. It wasn't process—

Ms. MORTENSEN. More outcome-focused.

Chairman ROSKAM. Outcome.

Ms. MORTENSEN. Right.

Chairman ROSKAM. Right. So that is your—

Ms. MORTENSEN. So—

Chairman ROSKAM. That is your substance.

Ms. MORTENSEN. So I think this is challenging, right? And so there are commissions that have gotten together. So there is an international consortium on health outcome measures by Porter and a few others at Harvard. So I think it is a great place to start looking at what are validated outcomes measures that are being used not in the United States only, but across the world.

But also, to tie back to focus groups with the Medicare beneficiaries, what is it you want to learn? And often, what they want to learn are what are called patient-reported outcomes. So maybe step back—I had to say this, as a researcher—but step back from what is calculated in the claims data, and allow these beneficiaries to respond on patient-reported outcomes, or patient-reported outcome measures, which you actually see incorporated in the MIPS much more so than in the Medicare Advantage themselves.

I think also metrics like healthy days that these insurers are already capturing—you know, Humana is doing the healthy days, and MedPAC has proposed the healthy days at home metric—things that give the individual a better sense about what type of care can I expect to receive, but also this gives the plans and incentive to focus more on social determinants of health, because they can point to these outcomes and say, hey, look, if we can get them more healthy days at home, however we do that, we are going to score better on our—

Chairman ROSKAM. Are healthy days at home—is that as intuitive as it sounds? Like days that they are not getting care?

Ms. MORTENSEN. That is right. And so they had researchers at Harvard say, “Show us”—this MedPAC commission—“Show us what this would look like. Show us how we measure it, what goes in, what goes out.” So of course, Humana is going to measure it maybe differently than Harvard did—

Chairman ROSKAM. Sure.

Ms. MORTENSEN [continuing]. But you could agree on a match rate where—and you could see if that is useful or not.

But this may be one that health plans don't score well on—

Chairman ROSKAM. Yes.

Ms. MORTENSEN [continuing]. But it is still meaningful to the beneficiaries.

Chairman ROSKAM. And the theory is if you measure it, that is—you are going to get more of what you measure, basically.

Ms. MORTENSEN. Exactly.

Chairman ROSKAM. Is there a plot trap in there, kind of cooked in to this story line, where health plans or others are being held to an account for things over which they have no control?

So, in other words, if I am a patient, and I am getting all the good advice, and I am acting with impunity, there is only so much that others can do for me. Is there a recognition in sort of this evaluation model that people still make choices; they can make bad choices, too?

Ms. MORTENSEN. Yes, I think that comment is very appropriate. Although you talk to the health plans, they would like to see more outcome-based measures. But we always know that there are things outside of the health care system that can affect that.

But you will see some of the measures in there, and we will say, "Was the patient adherent to their therapy?" And so that is not an outcome, but it is what you call an intermediate outcome, because adherence to your therapy would prevent a downstream, even more significant event.

So focusing more on those intermediate outcomes would be important, as well. Was the patient adherent, so right now we look are their blood levels under control for a diabetic patient. Why not look at average levels and compare that across time? So rather than just being sort of threshold, you could look at averages and compare those, and look for improvement across time, as well.

Chairman ROSKAM. Ms. Klausner, if head nodding is any indication of something to say, you have something to say.

Ms. KLAUSNER. Sorry, I was quite transparent. So I do think that there are a number of Star Rating measures that the plan can't control. Like for instance, overall rating of the health plan.

With 40-plus measurements, there—many of them are under our control, but again, when a CAP survey—which is the survey that is sent to the beneficiaries—arrives in somebody's home and it is a paper survey, and they are asking the overall rating of the health plan, you don't know what could have happened to somebody that day. Maybe they waited in their doctor's office for two hours—

Chairman ROSKAM. Right.

Ms. KLAUSNER. Very likely. And all the sudden they have a bad rating of the health plan, even though it was not something, obviously, that we could control.

So there are measurements on there that I think are out of the plan's control. I think we would like to work with CMS to figure out which ones are controllable by the plan truly, and which are not.

Chairman ROSKAM. Is there good work that is being done? Because some of that is just—that is life, right? So we are held to account for things over which we don't have control, and that is life. How do you—and I am not trying to be cavalier about it, but how do you discern, then, you know, what is really—those things that are—that you do have control over? Is there good work that is being done on this, academic work and so forth?

Ms. KLAUSNER. I will defer to Dr. Mortensen for the academic work. I think that you are right, though, that is just life, and I think health plans have taken that to be it is what it is.

And so we do control and work towards measurements that we can control. We try to educate beneficiaries, we try and educate them about the Star Rating system. And we accept it. But if we have an opportunity to make comments on things that we would like to see changed, that would be one of them.

Chairman ROSKAM. Okay. Mr. Toy, in part of your testimony it was—you were focusing in on barriers to entry. Just kind of just quickly, can you give a snapshot for what this arena is like when you are a new entrant in it? And what could we do that would lower barriers? Because, by definition, that is a better thing. But we don't want to lower them so that, it is just de minimi and there is no standard whatsoever. Where is the balance?

Mr. TOY. Yes. Well, I can let you know what we think the balance is. So when we enter a new market, like we are going into a new county, into a new state, almost certainly there will be other plans in there. There will be fee-for-service, there will definitely be probably some other MA plans already there.

A lot of times the providers in that area will be consolidated, they will be big groups, they may have very strong deals with existing MA plans already. And that may disincentivize them for the contract of a new MA plan, especially one which, by definition, has low leverage, because we don't have membership in that state, because we are new.

And so that is just like a very difficult cycle to break, because we don't have membership, we can't get the providers, they don't want to contract with us yet because we don't have leverage, so they make it very, very expensive, minimally. And so that is basically what it looks like.

Our suggestion is that perhaps we say everyone in Medicare should be treated equally, whether you are in fee-for-service, or whether you are on Medicare Advantage.

And what that means is if providers are accepting fee for service, they should be accepting Medicare Advantage folks, as well. They shouldn't be able to turn away Medicare Advantage people, just because they chose a new plan that they might like, which is innovative. We will negotiate in good faith. We can prove that we are doing that. But we want some balance there.

Chairman ROSKAM. Okay. Let's see. Quickly, Mr. Kelly. You have got an article on Path Finder?

Mr. KELLY. Yes, Mr. Chairman. I would like to submit this for the record. This is from The Hill on May the 4th, 2018, an article that is titled, "Mr. President, Let Markets Help Save Medicare," and I would like to submit that without objection.

Chairman ROSKAM. Without objection, so ordered.



Mr. President, let markets help Medicare

BY JOHN HART, OPINION CONTRIBUTOR — 05/04/18 04:30 PM EDT
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Imagine if an American president who was unhappy with a company like [Amazon.com](#) proposed the creation of taxpayer-funded site called [Retail.gov](#) to do retail right. As odd as that sounds, that's precisely what happened when President Obama created [HealthCare.gov](#). Companies that were already in the e-commerce space like eHealth, which created the e-commerce infrastructure for buying and selling health insurance online, suddenly found themselves forced to compete with a heavily subsidized taxpayer-funded site.

Fortunately, the Trump administration has expressed its desire to "wind down" the Affordable Care Act's federal exchanges and [HealthCare.gov](#) in its recent budget request. Yet, some are now urging the Trump administration to essentially repeat Obama's mistakes and heavily invest in "improving" the consumer shopping experience in a far more costly and expensive area: Medicare.

A new report by a health care coalition describes the federal government's effort to help seniors navigate the Medicare program as woefully inadequate. The Medicare Plan Finder tool on [Medicare.gov](#) earned seven grades of "D" or "F" according to the Clear Choices Campaign, a joint project of the Council for Affordable Health Coverage and the National Council on Aging (NCOA).

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The report concludes the “website layout and display are confusing,” “language is not user-friendly,” and “human support is not available.”

The results are hardly surprising. The federal government isn’t built to do e-commerce well. The troubled launch of [HealthCare.gov](#) is Exhibit A. The site has cost more than [\\$9 billion](#) to date and the rollout was a debacle as my former boss, U.S. Senator Tom Coburn (R-Okla.) detailed in his [2013 Wastebook](#).

President Obama had to apologize to the country for the site not working while then-Health and Human Services Secretary Kathleen Sebelius described the launch as a “miserably frustrating experience.”

The Trump administration could easily go down this path in the Medicare space if they aren’t careful. The Clear Choices report describes the Medicare Plan Finder as more structurally flawed than [HealthCare.gov](#).

No amount of government funding will fix those flaws. Rather than competing with or duplicating private sector platforms that already help seniors navigate Medicare, the administration should let the private sector lead the way. Both taxpayers and consumers will get a better value.

Consider the eHealth experience. Even as it faces unnecessary competition from [HealthCare.gov](#), their cost of acquisition for new customers in the under-65 individual market is one-seventh that of the ACA’s Navigators program. Meanwhile, eHealth’s Net Promoter Score among Medicare shoppers (a widely adopted metric that measures customer loyalty) is 87. That’s nearly twice as high as the score for online hopping (44), three times as high as travel websites (30) and five times higher than traditional health insurance landing pages (17).

In the digital age, private sector platforms should be expected to outperform government. And they do. In the highly competitive e-commerce world, providing barely tolerable DMV-like customer service doesn’t cut it. Monopolies of mediocrity can survive in the public sector but they don’t last in the private sector, especially online.

This Tuesday, May 8, the House Ways and Means Committee will take a closer look at [Medicare.gov](#). Policymakers, staff and taxpayers should have their eyes wide open as they navigate the changing landscape of e-commerce and health care. A key lesson from the [HealthCare.gov](#) debacle is that government-backed sites can survive as long there is funding, but private sector platforms only exist if they provide exemplary customer service that keeps consumers coming back. In the digital age, that experience has real value for everyone – consumers, policymakers and taxpayers.

Medicare itself faces [insolvency](#) in just over a decade. For all the attention surrounding repealing and replacing ObamaCare, [Medicare cost](#) twelve times as much as the ACA this year (\$707 billion to \$58 billion). Every serious bipartisan proposal to save and protect Medicare for future generations offered in the past 20 years (i.e. plans offered by John Breaux, Alice Rivlin, Paul Ryan and Simpson-Bowles) incorporates competitive market forces to keep the program solvent. The federal government should welcome more of what the private sector is already providing. They’re going to need it.

The Clear Choices report offers the right diagnosis but proposes some wrong-headed prescriptions. An open ended marketing earmark for a

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flawed web tool could give seniors nothing more than a website to nowhere.

The federal government tried to outperform the private sector with [HealthCare.gov](#). It didn't work. The Trump administration can reverse that error and avoid making a new one with Medicare.

John Hart is the former communications director for Sen. Tom Coburn's (R-Okla.) and co-author, is the Founder of Mars Hill Strategies, a public relations and public affairs firm, whose clients include eHealth.

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Mr. KELLY. Thank you.

Chairman ROSKAM. Ms. Mortensen, back to you. Just in terms of the measures and so forth, you mentioned—are there 44 or 45—it seems an overwhelming number. Does it get to the point where the measurements are just—they have less and less meaning and they are taken less and less seriously?

Ms. MORTENSEN. Yes, that is a good question. So there were 44 in 2017 and 45 in 2018.

Chairman ROSKAM. I am listening.

[Laughter.]

Ms. MORTENSEN. And there are more than any other value-based program in the Medicare sort of array of programs. So they are pretty, you know, overwhelming.

Chairman ROSKAM. Well, what is the difference between making an evaluation at a plan level, and making it at a contract level?

Ms. MORTENSEN. That is a great question, because most of the evaluation is done at the contract level. And, you know, academics like us argue that that really takes away from the meaning of what is going on with any given plan, because everything is reported at the contract level.

Chairman ROSKAM. You just get less insight, and it is less discerning?

Ms. MORTENSEN. Sure, and it is more—I should be careful saying this, but there is more room for—it is a game for insurance companies now. Because if you are a contract and you have low-performing plans, what you do then is you just sort of smash them into your high-performing plans, and now across the board you have a very high-performing plan.

Chairman ROSKAM. Right.

Ms. MORTENSEN. At the contract level, which was not the design of the incentive payments, based off of the star quality metrics.

There is some legislation in the Bipartisan Budget Act to address this, but I think that—

Chairman ROSKAM. To address the evaluation at a plan level?

Ms. MORTENSEN. To address what happens to the Star Ratings once plans are consolidated together.

Chairman ROSKAM. I see.

Ms. MORTENSEN. So it is meaningful in that over 20 percent of Medicare Advantage enrollees over the last few years have been put into consolidated plans. So what that means, from the Plan Finder or the Star Rating perspective, is me over here in Miami, I am getting metrics that are reflecting plans that are sold in four different states. So it has not necessarily been meaningful for the beneficiary.

So yes, most of this is happening at the contract level. Where it arguably should be happening is MedPAC has proposed for many years it should be happening at the geographic level that is most meaningful to the beneficiaries.

Chairman ROSKAM. I get it.

Mr. Toy and Ms. Klausner, lastly, can you just give us a little bit of insight into your experience with encounter data submissions?

Mr. TOY. Yes. So with encounter data, we are already capturing most of the information that we require. Like, we are a very data-centric company. Like, we have already—we always capture data above and beyond claims and the clinical matching between the actual claim data and the clinical data is probably slightly easier for us than most. So we were able to meet the encounter data deadlines ahead of time. We have been able to comply. But I recognize that that is not always an easy thing.

Ms. KLAUSNER. And I would say that, for our plan, that we have seen improvements in the encounter data process over the last few years. It is much better than it was even a year ago. So we are pleased with that. I think there is still some outlier reports that come back to the plan that have errors, and I think we want those addressed before everything is finalized. But much improved over the last few years.

Chairman ROSKAM. Okay. Well, great. Look, on behalf of the whole Subcommittee, we really appreciate your time today. You are people of incredible background, each of you. You gave us great insight and a lot of things for us to process.

And I was teasing about Members coming in and out, but they have really absorbed what you have got to say, and have your written testimony, as well. So on behalf of the whole Subcommittee, we thank you for your time and your testimony.

And the Committee is adjourned.

[Whereupon, at 11:47 a.m., the Subcommittee was adjourned.]

[Member Submissions for the Record follow:]

Clover

Questions for the Record
Hearing on The Current Status and Quality in the Medicare Advantage Program
May 8, 2018

Representative Paulsen (R-MN)

***Question:** As you probably know, the 21st Century Cures Act will allow patients with end stage renal disease (ESRD) to select a Medicare Advantage (MA) plan beginning in 2021. ESRD patients are medically complex – but stand to benefit greatly from an MA plan’s ability to coordinate care and tailor benefits to a beneficiary’s needs. For the growing number of Medicare beneficiaries struggling with chronic conditions like ESRD, this often means finding ways to support home and community based treatments. What has your health plan’s progress been thus far in finding ways to cover treatments like home dialysis for a clinically appropriate population?*

Clover Response: The 21st Century Cures Act includes a critical provision that will allow Medicare beneficiaries with end-stage renal disease (ESRD) to choose an MA plan. We applaud the legislation permitting Medicare beneficiaries access to comprehensive care coordination available in MA plans.

Clover Health (Clover) is a data and technology company that is dedicated to advancing the way Medicare beneficiaries are cared for via capturing and analyzing data to identify at-risk beneficiaries, and proactively intervening with our care management teams and our provider network to improve health outcomes, fill care gaps and reduce avoidable costs. The Clover business model is designed to rapidly generate new care delivery approaches and test their real-world effectiveness.

For people with many chronic conditions, care is fragmented among many different practitioners. To address this need, Clover is currently leading an effort to provide in-home care to its most vulnerable members. In this program, Clover providers are able to meet members in the setting that is most comfortable to them: their home. It also means much more frequent touch points with our members. We provide personalized care aimed at supporting the members' own goals for their own lives. Applying these experiences, we intend to provide similar, high-touch, personalized care for members with ESRD.

***Question:** MA plans have long been an appealing option for beneficiaries that struggle with chronic conditions, offering improved care coordination and more patient-centered coverage for individual needs. Has your health plan considered how to integrate home dialysis into its benefit offerings, given the well – documented benefits to dialyzing at home for a significant subset of the ESRD population?*

Clover Response: Some evidence suggests that complex care delivered through home primary care, with the backing of a coordinated multi-disciplinary care team, can improve the overall quality of care and quality of life for patients served, while lowering health

Clover

care costs.¹ With those considerations in mind, we are beginning a thoughtful analysis as to how the home dialysis benefits will fit into Clover's plans. We will be happy to share those experiences as we develop our plan offering.

***Question:** As your health plan embarks on designing an ESRD – appropriate benefit, have you yet come across any barriers to offering this improved care coordination and patient – centered care to the ESRD population, either at home or in center? What are those barriers, if they apply?*

Clover Response: One of the primary barriers in offering care and coverage to ESRD patients will be access to and coordination with dialysis providers. New MA plans like Clover do not have leverage to negotiate with the few dialysis providers in a given geography. Consequently, smaller plans are disadvantaged in the ability to offer competitive benefit packages.

¹ S. Klein, M. Hostetter, and D. McCarthy, "An Overview of Home-Based Primary Care: Learning from the Field," The Commonwealth Fund (June 7, 2017), available online: <https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/overview-home-based-primary-care-learning-field> (accessed Aug. 3, 2018).

Questions for the Record**Hearing on The Current Status and Quality in the Medicare Advantage Program May 8, 2018****Representative Chu (D-CA)**

Question: Dr. Hoadley, I'd like to ask you about access to the Medicare Plan Finder. In your testimony, you mentioned that many beneficiaries struggle to understand the jargon and complexities of the medical terms being presented on the Plan Finder in English. And I noticed in the National Council on Aging's report on Modernizing the Medicare Plan Finder gave the Plan Finder an "A" for language accessibility, because the tool can currently be translated into Spanish.

While I think translating the Plan Finder into Spanish is an important, and necessary, first step, I am concerned that giving the Plan Finder an A in this category implies that there is no additional work that needs to be done to improve language accessibility. For example, 47% of adults who speak Asian or Pacific Island languages are LEP - a larger share than any other linguistic group in the United States, including Spanish speakers.

Dr. Hoadley, in addition to simplifying the jargon in the Plan Finder, do you think that the tool could do more to be accessible for individuals who speak languages other than English or Spanish?

Answer: Thank you for the question. The grading of the Plan Finder by the National Coalition on Aging and the Clear Choices Campaign was based on the criterion of whether the Plan Finder featured non-English language translation services for at least one language and/or access to assistance. It was scored a grade of A based on a link at the top left of the page to translate into Spanish. I agree with your important point that the Plan Finder tool should be accessible in more languages than English and Spanish. Therefore, the A grade should not suggest that work on accessibility is complete.

In my view, it would make sense for CMS to adopt rules requiring that translation requirements are triggered any time use of a non-English language exceeds some designated threshold, based on the percentage or absolute number of people in a geographic area. Such a rule would be especially important for marketing materials used by Medicare Advantage plans or Part D plans. For example, a Medicare Advantage plan offered statewide in California might be required to make materials available in any language used by more than a certain number of Medicare beneficiaries in the state.

It is my understanding that the 1-800-Medicare customer service number offers some access to translation services in a variety of languages, including Arabic, Armenian, Chinese, Farsi, French, German, Haitian Creole, Italian, Japanese, Korean, Polish, Portuguese, Russian, Tagalog, and Vietnamese. That is a good first step.

But we should go beyond that. For a national online tool such as the Medicare Plan Finder or a print tool such as the "Medicare and You" handbook, CMS should study which languages are most commonly spoken by Medicare beneficiaries. To your point, it would be important to consider the share of speakers for any language who have limited English proficiency. Based on this information, CMS should make these tools available in several additional languages.

The cost of making the Plan Finder accessible in several additional languages should be minimal compared to the benefits of greater access to these important educational materials.



[Public Submission for the Record follow:]



INSTITUTE FOR
CRITICAL CARE
FOUNDATION

Statement of the
Institute for Critical Care Foundation
before the
Health Subcommittee
of the
Committee on Ways and Means
of the
U.S. House of Representatives

“Hearing on the Medicare Advantage Program”

May 8, 2018

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Ways and Means Committee
Hearing on the Medicare Advantage Program
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BACKGROUND

The Institute for Critical Care Foundation (“ICCF”) is a private operating foundation established to support scientific research and education pertaining to the delivery of critical care, rehabilitation medicine and specialized post-acute care. ICCF pursues its mission by: 1) conducting, commissioning and supporting research to help improve the quality of critical care and ensure access to the specialized treatment needs of patients recovering from severe injury or illness; 2) educating the public, academia and the medical community about its research findings; and 3) contributing to the development of public policy impacting the delivery of critical care services by submitting research briefs, policy statements, whitepapers and amicus briefs to relevant policy-makers.

ICCF appreciates the opportunity to comment for the record on recent trends in the Medicare Advantage program and its use of post-acute care services. As an organization dedicated to advancements in the treatment of patients recovering from critical illness and injury, and the promotion of related scholarship and education, we are grateful for the Committee’s willingness to periodically review the performance of the Medicare Advantage program, and for your review and consideration of our comments below.

CONCERNS

Although, Medicare Advantage (MA) plans are required to cover all services covered under Original Medicare,¹ recent data indicates that beneficiaries enrolled in Medicare Advantage plans may be being denied access to care in certain post-acute care settings, despite their eligibility and need for these services.

¹ Social Security Act § 1852(a)(1). See also *Medicare Advantage Plans cover all Medicare services*. Medicare.gov. Viewed on May 1, 2018. <https://www.medicare.gov/what-medicare-covers/medicare-health-plans/medicare-advantage-plans-cover-all-medicare-services.html>

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RECENTLY PUBLISHED LITERATURE

In its most recent Report to Congress (March 2018), the Medicare Payment Advisory Commission (MedPAC) has concluded that Medicare Advantage plans refer fewer patients to post-acute care (PAC) and utilize lower cost PAC settings, as compared to the traditional Fee-for-Service (FFS) program.² Similarly, a recent study by Huckfeldt et. al,³ found that Medicare beneficiaries with MA coverage were less likely than those in FFS Medicare to be admitted to inpatient rehabilitation facilities (IRFs). This difference occurred between MA and FFS beneficiaries who were discharged from the same short-term acute care hospital. In addition, Huckfeldt also concluded:

- MA beneficiaries were 3.3 percentage points less likely than FFS beneficiaries to be admitted to any post-acute care facility—either a skilled nursing facility (SNF) or an IRF;
- MA beneficiaries were 2.0 percentage points more likely to be admitted to a SNF, when beneficiaries were eligible for IRF care;
- For stroke patients (where the prospect of functional restoration is often greatest with intensive rehabilitation) the differences were even greater --- with referrals to IRFs for MA enrollees significantly lower (17.4 percent) than for FFS beneficiaries (24.8 percent).

Lastly, and perhaps not surprisingly given the data noted above, Huckfeldt also suggests that MA plans' use of select provider networks has resulted in significant differences in post-acute care provider access for MA enrollees versus FFS beneficiaries. Across all conditions, MA beneficiaries had access to an average of 16 SNFs, as compared to an average of 30 SNFs for FFS beneficiaries. A similar trend was observed for IRFs.

² Chapter 7—*Post-Acute Care: Increasing the Equity of Medicare's Payments within Each Setting*. March 2018 Report to the Congress: Medicare Payment Policy. March 15, 2018. Page 191.

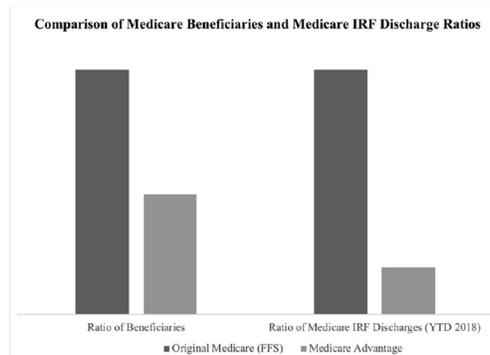
³ *Less Intense Post-Acute Care, Better Outcomes for Enrollees in Medicare Advantage than those in Fee-for-Service*. Huckfeldt, et. al. Health Affairs. January 2017.

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NEW—BREAKING—DATA

Unfortunately, there are few studies like Huckfedt in the public domain that examine the question of whether Medicare beneficiaries have equal access to critical care services when comparing FFS to MA.⁴ This has prompted the ICCF to launch an analysis to better understand the available data that could be used to answer this question. Although our analysis is in its preliminary stages, we are releasing the following high-level statistics to begin a dialogue on this important topic:

- In its March 2018 Report to Congress, the Medicare Payment Advisory Commission concluded that approximately 68-percent of beneficiaries received services under FFS and 32-percent under MA.⁵ Given this data, one can reasonably assume the expected ratio of IRF services is also 2:1.
- Our data analysis (Attachment A) found the observed ratio is actually 5:1. We expected a 2:1 ratio, but found a 5:1 ratio—meaning there is an unexplained 3:1 ratio that needs further research. At this time, we have not adjusted for common factors, such as age and we will conduct further analysis to better understand this discrepancy.



⁴ *An Overview of the Critical Care Continuum*. April 25, 2018. <https://www.instituteforcriticalcare.org/issue-briefs>

⁵ *Chapter 13—The Medicare Advantage Program: Status Report*. March 2018 Report to Congress. March 15, 2018. Page 353.

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- To compound the discrepancy further, the same data also yielded a staggering discrepancy with the IRF 60-percent rule.⁶ On average for a given IRF, the FFS compliance rate was 69.37-percent as compared to 82.67-percent compliance rate for MA. We are still exploring the underlying reasons for this 13-percent difference—which is likely the result of beneficiaries being eligible for the IRF benefit, but not receiving access to those services.

DISCUSSION

The growing anecdotal evidence and our preliminary analysis of 2018 nationwide IRF discharge data provide reason for concern. The data suggest that there significant and unexplained differences in the utilization of PAC services by Medicare beneficiaries in and out of the MA program.

Furthermore, it should be noted that all IRF admissions require an independent determination of medical necessity by a practicing physician. In the case of an FFS beneficiary, it is typically the patient’s treating physician who refers them to an IRF. The patient’s eligibility, and the medical necessity and appropriateness of the IRF care, must then be subsequently confirmed by the admitting facilities’ medical director. Conversely, patients in MA plans typically must have referrals to a PAC provider pre-approved by the plan’s medical director. The variations in PAC utilization rates suggests that treating physicians and plan medical directors may approach the medical necessity decision differently. This alone is concerning.

However, when one considers the economic incentives of MA plans (which are capitated) and that the typical enforcement of fraud and abuse laws provides little parity in the way these important “medical necessity” decisions are scrutinized retroactively, it creates even greater concerns for

⁶ For the purposes used herein, presumptive compliance is defined as an IRF with at least 60-percent of annual discharges that map to one of more the 13 conditions required at 42 CFR 412.29(b)(2). For additional details see *IRF Classification Criteria*. Viewed on May 4, 2018. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html>

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ICCF that patients in MA plans may be being subjected to a different and potentially questionable medical necessity standard.

To elaborate on this point, consider that treating physicians and PAC providers are clearly subject to and have often been the targets of many, large-scale fraud and abuse actions – actions alleging inappropriate referrals, resulting in overutilization and the defrauding (*or financial abuse*) of the Medicare program. The threat of a fraud action thus acts as an ongoing and significant check (and appropriately so) on the potential for inappropriate referrals in the FFS side of the program. Conversely, the fraud and abuse laws have been used much less frequently against Medicare Advantage plans, and then typically only for fraudulent administrative practices meant to increase capitation payments – and rarely if ever to challenge a plan’s clinical practices (*i.e., clinical abuse*). Given this underlying, environmental context, we find the discrepancies in PAC utilization between MA and FFS patients even more disconcerting.

RECOMMENDATIONS

Medicare covered post-acute care services are instrumental to the recovery of critically ill and injured patients. As the Committee considers which measures are appropriate for the MA program, we encourage Members to consider the data presented above. In the past, Congress has mandated specific quality measures to address perceived gaps in health care delivery. Additionally, the Committee has often been at the forefront of Congressional oversight of the Medicare program via the commissioning of investigations and analytical studies of actual practices in entitlement programs by the General Accounting Office, MedPAC and other governmental agencies. To better understand the extent and reason for the increasing deviations in the referral and use of post-acute care services between MA and FFS beneficiaries, we request that the Committee consider the following actions:

- **We recommend that Congress consider mandating a measure that determines the percentage of MA beneficiaries eligible to receive post-acute care who actually receive**

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such care. Such a measure should be publicly reported on an annual basis at the individual plan and county level.

- Further, to ensure that there is true parity between FFS and MA, **we recommend that Congress consider mandating the same measure set used in the IMPACT Act of 2014 (P.L. 113-185) in the MA program.**
- Additionally, to better understand the extent and the origins of these differences in utilization of PAC services, **we recommend that the Committee ask GAO to add a comprehensive analysis of the differences in utilization (and the impact thereof) of PAC services to its 2019 workplan.** Lastly, we recommend that the GAO examine and compare MA plan medical policies and medical necessity decision making practices to those conducted by treating physicians and PAC providers in the field, and to the relevant medical literature.

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ATTACHMENT A—DATA ANALYSIS

Our eRehabData⁷ database includes 350 IRFs. Our analysis reviewed Medicare data with dates of service from January 1, 2018 through May 2, 2018. This data yielded a total of 41,504 FFS IRF discharges and 7,959 MA IRF discharges. Although this is raw data that has not been fully adjudicated by the Centers for Medicare & Medicaid Services (CMS), it is assumed that these are IRF discharges that are fully compliant with all rules and regulations. Therefore, the total universe of Medicare IRF discharges in our sample is 49,463.

Using percentages, we found that 84-percent $((41,504/49,504)*100)$ of the total IRF discharges were FFS and 16-percent $((7,959/49,504)*100)$ of the total IRF discharges were MA. From this data we can reasonably assume that for every MA discharge in an IRF data set, we would find five corresponding FFS discharges.

The eRehabData database provides an ongoing analysis of an individual IRF's compliance with the 60-percent rule, in real-time, on a daily basis. eRehabData calculates compliance with the 60-percent rule individually for FFS and MA. eRehabData uses the definition at 42 CFR 412.29(b)(2) to determine compliance.

⁷ eRehab Data. <https://web2.erehabdata.com/erehabdata/index.jsp>

